Ear Institute of Chicago, LLC

950 N. York Road, Suite 102
Hinsdale, IL 60521

233 E. Erie, Suite 701
Chicago, IL 60611

1000 Central, Suite 610
Evanston, IL 60201

PATIENT HEALTH HISTORY

Patient Name:____Date of Birth:___________________

CHIEF CONCERN

Reason for today's visit:____

PAST MEDICAL HISTORY

Please list any prior major illnesses and/or injuries:____
____
____

SURGERIES/HOSPITALIZATIONS	YEAR

MEDICATIONS (List Name, dosage and frequency)

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

DRUG ALLERGIES:____

FAMILY HISTORY

(List family member and history of hearing loss, dizziness, migraine or acoustic tumor)

SOCIAL HISTORY

Occupation:____

History of smoking?: No ____ Yes ____ If yes, what type and for how long?____________________

History of alcohol use: No_____ Yes____ How often?____

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REVIEW OF SYSTEMS (Please circle all items that you have had problems with)

Constitutional
Fever
Weight Loss
Excessive Fatigue
Night Sweats

Eyes
Wear glasses/contacts
Infections
Injury
Glaucoma
Cataracts

Ear, Nose, Throat & Mouth
Wear Hearing Aid
(Date of last exam_____)
Hearing Loss
Ear Pain
Ear Infection
Ringing in the Ear(s):
Left___ Right___ Both___
Balance Disturbance:
Vertigo____
Spinning____
Unsteadiness_____
Floating Sensation____
Lightheadedness____
Nosebleeds
Nasal Congestion
Nasal Drainage
Inability to Smell
Sinus Problem
Sinus Headaches
Sore Throat
Mouth Sores

Cardiovascular
Chest pain or angina
High Blood Pressure
Irregular Pulse
Heart Murmur
High Cholesterol
Swelling in Feet and Hands
Leg Pain/Cramping While Walking

Respiratory
Asthma
Chronic Cough
Emphysema
Shortness of Breath
Bronchitis
Pneumonia
Lung Cancer
Bloody Sputum

Indigestion and Pain with Eating
Nausea
Vomiting
Blood in Vomit
Liver Disease
Jaundice
Abdominal Pain
Change in Bowel Habits
Ulcers or Gastritis
Colon Cancer

Genitourinary
Urinary Tract Infection
Painful Urination
Blood in your Urine
Difficulty Starting/Stopping Stream
Incontinence
Kidney Stones
Prostate Cancer
Endometriosis
Uterine or Cervical Cancer

Musculoskeletal
Broken Bones
Arm or Leg Weakness
Back Pain
Arm or Leg Pain
Joint pain or Swelling
Arthritis

Integumentary
Skin Disease
Skin Cancer
Breast Pain, Tenderness or Swelling
Nipple Discharge

Neurological
Fainting Spells or Blackouts
Seizures
Migraine Headaches
Problems with Memory
Disorientation
Difficulty with Speech
Inability to Concentrate
Double or Blurred Vision
Face Weakness
Coordination in Arms and/or Legs

Psychiatric
Anxiety/Depression
Other Psychiatric Disorder:
____

Endocrine
Diabetes
Thyroid Disease
Increased Appetite
Excessive Thirst or Urination
Hormone Problems

Hematologic/Lymphatic
Anemia
Hemophilia
Bleeding Tendency
Persistent Swollen Glands or Lymph Nodes
Blood Transfusion
Date:_________

Allergic/Immunologic:
Food Allergies
Inhalant (nasal) Allergies
Immunologic Disorder:__________

The above information is accurate to the best of my knowledge:

Patient (or Guardian) Signature:____ Date:____________

The above information has been reviewed with the patient and is deemed correct:

Physician:____ Date:____________

Revised 10/6/04