

NAME _____ Date _____

Age _____ Date of Birth _____ Male / Female

CURRENT PROBLEMS: Hearing loss Tinnitus (ear noise) Pressure in ears

Dizziness

Pain in or around ears

ALLERGIES to Medications _____

Other Allergies _____

MEDICATIONS currently taking _____

HISTORY - EARS

Hearing Loss: Right Left Equal None

Hearing aids: Right Left None If so, when? _____

Tinnitus (ear noise): Right Left None If so, when? _____

Ear Pain: Right Left None If so, when? _____

Surgery: Right Left None If so, when? _____

Type of surgical procedure performed? _____

Drainage: Right Left None If so, when? _____

Childhood Infections: Right Left None If so, when? _____

Ventilation Tubes: Right Left None If so, when? _____

HISTORY - DIZZINESS (circle appropriate description of dizziness) NONE

Outside moves Head spins Light-headed Fainting feeling

Imbalance Staggering or Falling Nausea or Vomiting Ear pressure

Date of onset of symptoms: _____ Duration of symptoms: _____

Cause or aggravation of symptoms, if known: _____

Worse when lying on your: Right Side Left side Neither

Occurs with hearing loss: Right Left Neither

(continued)

HEAD X-RAYS: Have you had any? CT or MRI Where: _____ When: _____

HISTORY: (General) (Please check *all* of the following that you have or have had):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bursitis (TRJ) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Meningitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Imbalance | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Change in hearing | <input type="checkbox"/> Head trauma | <input type="checkbox"/> Lump in Neck | <input type="checkbox"/> Problems Sleeping |
| <input type="checkbox"/> Visual Loss | <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Facial Paralysis | <input type="checkbox"/> Slurred Speech | <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness in Legs |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pain in Joints | <input type="checkbox"/> Skin Problems |

Non-Ear Surgeries

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Reactions to Anesthesia (please check):

- | | |
|---|--|
| <input type="checkbox"/> No abnormal reaction | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Post-operative bleeding |

SOCIAL HABITS

Smoking? Packs daily _____ How long? _____ When did you stop? _____

Caffeine? Coffee _____ Tea _____ Cola _____ If so, how much daily? _____

Alcohol? What type? _____ How often? _____

Diet: Regular: _____ Special: _____

Exercise: Type: _____ How often? _____

Addictions: Type: _____ If treatment, when? _____

FAMILY HISTORY

EAR: Hearing Loss _____ Dizziness _____ Which relative? _____

Brain/Nervous System Diseases: _____

Bleeding Disorders: _____