

The Ear Institute of Texas, P.A.

HEALTH HISTORY

Welcome to our practice. As a new patient, please complete the information requested below to the best of your ability.

Patient Name _____ Birth date ____ / ____ / ____

Chief Complaint/Reason for today's visit: _____

Previous Hospitalizations/Surgeries	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History

Have you ever had the following: (Circle "yes" or "no", leave blank if uncertain)

Meningitis.....	Yes	No	Cancer.....	Yes	No	Hives or Eczema.....	Yes	No	Please list <u>ALL</u> other illnesses, past or present: _____ _____ _____
Heart Disease.....	Yes	No	If yes, where? _____			AIDS or HIV+.....	Yes	No	
Arthritis.....	Yes	No	Spine/Back Problems..	Yes	No	Stroke.....	Yes	No	
Epilepsy.....	Yes	No	If yes, where? neck thoracic lumbar			Hepatitis.....	Yes	No	
Migraine Headaches..	Yes	No	High Blood Pressure...	Yes	No	Kidney Disease.....	Yes	No	
Other Headaches.....	Yes	No	Low Blood Pressure...	Yes	No	Thyroid Disease....	Yes	No	
Diabetes.....	Yes	No	Asthma.....	Yes	No	Bleeding Tendency	Yes	No	

Patient Social History

Occupation: _____

Marital Status: Single:____ Married:____ Separated:____ Divorced:____ Widowed:____

Do you have children: Yes ___ No ___ If yes, how many? _____

Do you smoke? Yes ___ No ___ I quit ___ years ago If you have smoked: ___ packs of cigarettes per day for ___ years.

Do you drink alcohol? Yes ___ No ___ No, but I used to ___

If yes, how often? Daily: ___/day 1 or more times a week: ___/week 1 or more times a month: ___/month Rarely ___

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)? Yes ___ No ___ If yes, explain: _____

Family Medical History

Family Member	Alive	Deceased	Approximate Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Brother/Sister	A	D		
Brother/Sister	A	D		
Brother/Sister	A	D		

Is there a history of hearing loss, dizziness, or ear problems in the family? Yes ___ No ___

If yes, please describe relation and condition: _____

Current Medications

Name	Dose	Frequency	Name	Dose	Frequency
_____			_____		
_____			_____		
_____			_____		

*Provide list of medications or write on reverse side of paper if more space is needed for medications.

Have you ever had problems with anesthesia? (Circle one): Yes / No

*****ALLERGIES TO MEDICATION: None ___ Please list any known allergies**

For pediatric patients only:
 Birth History: Full term ___ Premature ___ (___ weeks early) Vaginal Delivery ___ Caesarian Section ___
 Complication at Birth: Yes / No Required ICU care ___ Required ventilator ___ Had jaundice ___
 Immunizations: Up to date ___ Not Current ___