Health History Questionnaire

Date: _____

Name: _____ **Age:** _____ **DOB:** ____/_____/_____

Occupation: _____ ☐ Male ☐ Female

Referring Physician: _____

Primary Care Physician: _____

Chief Complaint: What symptoms are you having that brings you to this visit.

_____

Medications: Name Amount How Often

_____

_____

_____

_____

_____

Allergies: Are you allergic to any medications? Yes No

If so, which ones: _____

Past History:

General	None	Wt Change / Fatigue / Difficulty Walking
Eyes	None	Glaucoma / Cataracts / Double Vision
Heart	None	High Cholesterol / Hypertension / Heart Attack / Cardiac Disease
Lung	None	Asthma / Snoring / Sleep Apnea / COPD
GI	None	Ulcers / Reflux Disease / Hepatitis
Kidney	None	Stones / Renal Failure / Prostate / UTI
Musculo Skeletal	None	Arthritis / Fractures / Weakness / TMJ
Endocrine	None	Thyroid / Diabetes
Neuro	None	Migraines / Head Trauma / Stroke / Multiple Sclerosis
Immuno	None	Seasonal Allergies / Autoimmune / Sinusitis / HIV
Psych	None	Depression / Anxiety / Psychosis
Other History		

Past Surgical History:

Have you ever had ear surgery? Yes No

If yes, what type: _____

Have you ever had any other type of surgery? Yes No

If yes, what type: _____

Present Problem:

	Rt Ear	Lt Ear	Duration
Hearing loss	_____	_____	_____
Fluctuating Hearing	_____	_____	_____
Ear Fullness	_____	_____	_____
Ringing / Tinnitus	_____	_____	_____
Ear Infection	_____	_____	_____
Better Hearing Ear	_____	_____	_____
Hearing Aid	_____	_____	_____
Ear Pain	_____	_____	_____

Do you have dizziness Yes No (if no, skip this section)

If yes, When did it begin? _____
How long does it last? _____
How often does it happen? _____
Is your dizziness: ____ Mild ____ Moderate ____ Severe
Does your dizziness affect your work? ____ Yes ____ No
Does your dizziness affect your Driving? ____ Yes ____ No
Describe your Dizziness:

Spinning / Vertigo	____ Yes	____ No
Lightheadedness	____ Yes	____ No
Off Balance	____ Yes	____ No
Positional	____ Yes	____ No
Nausea	____ Yes	____ No
Headache	____ Yes	____ No

Family History: What medical problems run in your family? *including ear problems*

Father: _____
Mother: _____
Other: _____

Social History:

Noise Exposure _____
Do you smoke? Yes No How many cigarettes per day? _____
Do you drink alcohol? Yes No If yes, ___occasional ___moderate ___ frequent
Do you drink caffeine? Yes No

I acknowledge that the information stated above is true and complete:

_____ _____
Patient / Guardian Signature Date

_____ _____
Reviewing Physician Signature Date