

New Patient History

Name: _____ DOB: _____ Age: _____ Date: _____

Referring provider: _____

Family Doctor: _____

What are you being seen for today? *(When did symptoms start? How frequent? What makes them worse or better?)*

On a scale of 1 to 10, 1 being the worst and 10 being the best, how would you rate your overall hearing ability? **Worst 1 2 3 4 5 6 7 8 9 10 Best**

Current Medications *(Please list current medications or provide a list for us to copy)*

____ **No Medications**

Medication Allergies

Drug

Reaction

Date (approximate)

____ **No Known Drug Allergies**

Family History (Please indicate (F)ather, (M)other, (B)rother, (S)ister)

- | | | |
|---|---|--|
| <input type="checkbox"/> Adopted –limited-history | <input type="checkbox"/> Genetic mutations or syndromes | <input type="checkbox"/> Malignant hyperthermia (high fever during general anesthesia) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hayfever/allergies | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Diabetes (type)___ |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Immune deficiency | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Cystic fibrosis | | |

Past Medical History (Please check significant medical problems for which you have seen a doctor in the past)

- | | | |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Hayfever/allergies | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> RSV |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Attack/MI | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Arthritis
(type) _____ | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Auto Immune Disorder
(type) _____ | <input type="checkbox"/> Hospitalizations due to asthma | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Blood thinner use | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Thyroid nodules |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Tinnitus (ears ringing) |
| <input type="checkbox"/> Cancer
(type) _____ | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tonsil problems/tonsillitis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Trouble swallowing or dysphagia |
| <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Nasal obstruction | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Vertigo (room spinning) |
| <input type="checkbox"/> Diabetes (type)___ | <input type="checkbox"/> Obstructive sleep apnea | <input type="checkbox"/> Voice problems or hoarseness |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Other _____ | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Eczema | | |
| <input type="checkbox"/> Emphysema/copd | <input type="checkbox"/> Pacemaker or defibrillator | |
| <input type="checkbox"/> GERD/reflux | <input type="checkbox"/> Parkinsonism | |
| <input type="checkbox"/> Glaucoma | | |

Please continue to next page.

Past Surgical History (Please check surgeries you have had in the past)

- | | | |
|--|--|---|
| <input type="checkbox"/> Adenoidectomy and Tonsillectomy
(date) _____ | <input type="checkbox"/> Gall bladder or cholecystectomy | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Adenoidectomy
(date) _____ | <input type="checkbox"/> Gastric reflux (Nissen) | <input type="checkbox"/> Nasal surgery
(date) _____ |
| <input type="checkbox"/> Anesthesia problems
(List) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Head and neck skin cancer
(date) _____ | <input type="checkbox"/> Ovary removed |
| <input type="checkbox"/> Bariatric surgery (obesity) | <input type="checkbox"/> Heart bypass (CAGB) | <input type="checkbox"/> Retinal repair |
| <input type="checkbox"/> Bladder repair | <input type="checkbox"/> Heart valve repair | <input type="checkbox"/> Salivary gland
(date) _____ |
| <input type="checkbox"/> Bone fractures | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Sinus surgery
(date) _____ |
| <input type="checkbox"/> Bowel resection | <input type="checkbox"/> Hernia | <input type="checkbox"/> Spine surgery |
| <input type="checkbox"/> Breast biopsy (benign) | <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Thyroidectomy
(date) _____ |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tonsillectomy
(date) _____ |
| <input type="checkbox"/> Carotid cleanout | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Kidney transplant | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Ear reconstruction
(date) _____ | <input type="checkbox"/> Knee replacement | |
| <input type="checkbox"/> Ear tubes
(date) _____ | <input type="checkbox"/> Knee scope | |
| | <input type="checkbox"/> Lung removal
partial/whole | |
| | <input type="checkbox"/> Lung transplant | |

Social History (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Alcohol use <ul style="list-style-type: none">o Drinks per week: _____ | <input type="checkbox"/> History of illicit or street drug use (in past 10 years) Types: _____ |
| <input type="checkbox"/> Chewing tobacco <ul style="list-style-type: none">o Cans per week: _____o Date started: _____o Date stopped: _____ | <input type="checkbox"/> History of IV drug use |
| | <input type="checkbox"/> Never Smoked |
| | <input type="checkbox"/> Smoking history <ul style="list-style-type: none">o Packs per day: _____o Date started: _____o Date stopped: _____ |

If you are seeing Allergy today complete this section:

Environmental History (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Carpeting | <input type="checkbox"/> Housing rental,
Age of home: ____ | <input type="checkbox"/> Second hand smoke (list source) |
| <input type="checkbox"/> Central heat/air conditioning | <input type="checkbox"/> Indoor pets (list pets) | <input type="checkbox"/> Upholstered bedroom furniture |
| <input type="checkbox"/> Daycare | <input type="checkbox"/> In-home air filter | <input type="checkbox"/> Wet/damp basement |
| <input type="checkbox"/> Feather pillow | <input type="checkbox"/> Inner spring mattress | |
| <input type="checkbox"/> Housing owned,
Age of home: ____ | <input type="checkbox"/> Never smoker | |
| | <input type="checkbox"/> Occupation:
_____ | |