The Ear Institute of Texas, P.A.

HEALTH HISTORY

Patient Name _____ Age: _____ Birthdate _____/_____/_____

Chief Complaint/Reason for today's visit: _____

Previous Hospitalizations/Surgeries	**Year**	**Complications**

Have you ever had problems with anesthesia? Yes__ No__ If yes, what problems: _____

Have you had: Pneumonia vaccination within the last 5 years? **Yes**_ **No**__ Flu shot in the last year? **Yes**__ **No**__

Past Medical History

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

Meningitis……	Yes	No	Spine/Back Problems..	Yes	No	Hives or Eczema…….	Yes	No	High Cholesterol……..	Yes	No
Heart Disease…..	Yes	No	Bleeding Tendency	Yes	No	AIDS or HIV+……	Yes	No	Pacemaker…….	Yes	No
Arthritis……..	Yes	No	High Blood Pressure…	Yes	No	Stroke……..	Yes	No	**Please list ALL other illnesses,**		
Epilepsy……..	Yes	No	Low Blood Pressure…	Yes	No	Hepatitis A/B/C....	Yes	No	**past or present:** _____		
Migraine Headaches..	Yes	No	Asthma……	Yes	No	Kidney Disease…..	Yes	No	_____		
Other Headaches…..	Yes	No	Diabetes I or II……	Yes	No	Thyroid Disease….	Yes	No	_____		

Cancer…….. Yes No Type/Location: _____ Are you cancer free at this time? Yes No

Cancer treatments (Check all that apply): Surgery ____ Radiation ____ Chemo _____

Patient Social History

Occupation: _____

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

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

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 ____

Family Medical History

Please circle any of the following which have occurred in an immediate family member (parent, sibling, and children only - not by marriage/adoption)

For any circled, list relation (mother, father, etc.) and specific condition/symptoms below; if none, check here ___

Epilepsy	Asthma	Stroke	Migraines
Ear Problems	Kidney Disease	Thyroid Disease	Heart Disease
High Blood Pressure	Low Blood Pressure	Hemophilia	Diabetes

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 ☐ None ☐ See attached list

Please list all medications. If more space is needed, please attach an additional sheet of paper

Name	Dose	Frequency	Name	Dose	Frequency

Preferred Pharmacy:_____ Location:_____ Phone #_____

Primary Care Physician:_____

*****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 ___