Medical History Form V.3.16 – Adult
The Ear Center of Greensboro, P.A., 1126 N. Church St. St., #201, Greensboro, NC 27401
Please fill in the blank or circle the answer where appropriate:

Patient Name:_____Age:_____Gender: _____Date:_____
CC: What problem are you here to have evaluated?_____
_____
HPI: Where is the problem? _____ Right / Left
Describe the problem_____
How long have you had the problem?_____ How long does it last?_____
How severe?_____ When do you experience the problem?_____
What situations bring on the problem?_____
What will change your symptoms?_____
What other signs or symptoms occur with this problem?_____

PMH: Please list any serious illnesses or injuries that you have had:_____
What surgery(s) have you had?_____
List any medications & the doses that you take:_____
_____
Are you **ALLERGIC** to any medications? Yes / No Please list them:_____
_____
Family History: List any history of inherited diseases in your family, EX: diabetes, heart disease, hearing loss, problems with anesthesia? (N/A if there are none)_____
_____
Social History: (circle) Married Single Divorced Other **Employed**: Yes /No/Retired
Job Title:_____ Race:_____ **Level of Education**:_____
Previous Military History: Yes /No_____ **Noise exposure:** Yes /No _____
Do you smoke?/Use Tobacco? Yes/No **How often?_____** **Have you used illegal drugs**? Yes/No
Do you use alcohol? Yes/No **How often?_____** **Have you been exposed to HIV?** Yes/ No
Ethnicity (circle): Non-Hispanic, Hispanic, Not Specified **Preferred Language**: English, Spanish, Other_____

Review of Medical Systems: Have you had any diseases that involve the following areas?
Circle diseases, write any other problems in blanks or check if normal.

	Normal
Constitution: Fever, weight loss, night sweats,_____	_____
Eyes: Loss of vision, cataracts, glaucoma_____	_____
Ears, Nose, Throat issues:_____	_____
_____	_____
Cardiovascular: High Blood pressure, chest pain, heart attack, irregular pulse, circulation problems	
_____	_____
Respiratory: Asthma, emphysema, chronic bronchitis_____	_____
Gastrointestinal: Reflux, ulcers, liver disease, nausea_____	_____
Musculoskeletal: Arthritis, osteoporosis, fibromyalgia_____	_____
Skin/ Breast: Dermatitis, skin cancer, breast cancer_____	_____
Neurologic: Headache, migraine, stroke, TIAs, seizures_____	_____
Psychiatric:_____	_____
Endocrine: Diabetes, thyroid disease_____	_____
Hematologic: Anemia, Bleeding disorder, sickle cell disease_____	_____
Allergic/immunologic: Allergies, hay fever, autoimmune disorder_____	_____
Cancer_____	_____
Other comments or problems:_____	_____
_____	

EARC 3.16 Patient or Parent Signature:_____M.D. initials_____