

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 _____

Job Title: _____ **Race:** _____

Previous Military History: Yes / No _____

Do you smoke?/Use Tobacco? Yes/No **How often?** _____

Do you use alcohol? Yes/No **How often?** _____

Ethnicity (circle): Non-Hispanic, Hispanic, Not Specified _____

Employed: Yes /No/Retired

Level of Education: _____

Noise exposure: Yes /No _____

Have you used illegal drugs? Yes/No

Have you been exposed to HIV? Yes/ No

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.

Constitution: Fever, weight loss, night sweats, _____ Normal _____

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 _____