# Medical History Form V.8.15 – 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? ___________________________________ Left / right

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 the problem(s)? ______________________________________________

**PMH:** List any serious illnesses or injuries that you have had: _____________________________________________

What surgery have you had? __________________________________________________________________________

List any medications and the doses that you are taking: _______________________________________________________

________________________________________________________________________________________________

Are you **ALLERGIC** to any medications? Yes / No please list them: _____________________________________________

________________________________________________________________________________________________

**Family History:** List 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. Place check mark if normal.**

| | Normal |
|---|---|
| Constitution: Fever, weight loss, night sweats, ____________________ | ______ |
| Eyes: Loss of vision, cataracts, glaucoma____________________ | ______ |
| Ears, Nose, Throat: ____________________ | ______ |
| ____________________ | ______ |
| 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, seizure____________________ | ______ |
| Psychiatric: ____________________ | ______ |
| Endocrine: Diabetes, thyroid disease____________________ | ______ |
| Hematologic: Anemia, Bleeding disorder, sickle cell disease____________________ | ______ |
| Allergic/immunologic: Allergies, hay fever, autoimmune disorder____________________ | ______ |
| Cancer____________________ | ______ |
| Other comments or problems: ____________________ | ______ |

________________________________________________________________________________________________

EARC8.15 Patient or Parent signature: _______________________________________M.D. initials______