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EAR NOSE & THROAT
ASSOCIATES OF LUBBOCK

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Hearing Aids

Name ____________________________ DOB ___________ Age ________ Sex M F
Date ____________ Height __________ Weight _________ Chart# _____________________

1) Describe the **major reason** for today's visit: ____
____
____
____

How long has this been present? _______ Days ______ weeks ______ months _______ years
Any previous episodes? □ Yes □ No When: ____
Any associated symptoms? □ Yes □ No What: ______________________________________
Prior treatment? □ Over-the-counter medicines: ____________________________________
□ Prescription medicines: ____
□ Previous doctors visited: ____

2) Is there a **second problem** you would like evaluated? ______________________________
____
____

Any previous episodes? □ Yes □ No When: ____
Any associated symptoms? □ Yes □ No What: ______________________________________
Prior treatment? □ Over-the-counter medicines: ____________________________________
□ Prescription medicines: ____
□ Previous doctors visited: ____

3) Illnesses: Do you have or have you ever had any of the following? Please check all that apply.

□ Tuberculosis (TB)
□ Chronic lung disease
□ Asthma
□ Cancer (please specify): _________________
____
____
□ Pneumonia
□ Diabetes. Do you take insulin? □ Yes □ No
□ Kidney Disease
□ High Blood Pressure
□ Previous Stroke
□ Ulcers
□ Migraine Headaches

□ Seizure disorder
□ Allergies
□ Ear Infections
□ Sinusitis
□ Bleeding disorder
□ Anesthetic reactions
□ Heart disease. Have you had a heart attack?
□Yes □ No. If so, when? ___________
□ Thyroid Disease
□ Arthritis
□ Hepatitis
□ HIV

□ Other: ____
____

If this appointment is for your child, is he/she up-to-date on immunizations? □ Yes □ No
Have you ever been hospitalized for any medical problems? □ Yes □ No
If yes, please list: ____

____

____

4) Surgeries: Have you ever had any of these surgeries? Please check all that apply and, if possible, give the date (month and year).

□ Adenoidectomy
□ Ear Surgery
□ Ear Tubes
□ Neck surgery, specify: ______________________
□ Septoplasty
□ Sinus surgery, specify: ______________________
□ Throat surgery, specify: ______________________
□ Thyroidectomy
□ Tonsillectomy
□ Aortocoronary Bypass
□ Appendectomy
□ Carotid Endarterectomy
□ Cholecystectomy (Gall Bladder removal)
□ Hemorrhoidectomy
□ Hernia Repair
□ Hysterectomy
□ Prostatectomy

Any other surgeries? ____

____

5) Medications: Please list <u>prescription</u> medications being taken.

Medication	Strength	How many times per day?

Please list <u>over-the-counter</u> medication being taken.

Medication	Strength	How many times per day?

Do you take aspirin or arthritis medication on a regular basis? □ Yes □ No

Medication	Strength	How many times per day?

Do you take blood thinners? □ Yes, please list □ No ______________________

6) Allergies: Allergies to medications

Penicillin □ Yes □ No Reaction: ______________________
Codeine □ Yes □ No Reaction: ______________________
Sulfa □ Yes □ No Reaction: ______________________
Other: ______________ Reaction: ______________________
Allergies to food? □ Yes □ No Reaction: ______________________
Allergies to tape, iodine, latex? □ Yes □ No Reaction: ______________________
Allergies to pollen, dust, animals? □ Yes □ No Reaction: ______________________

7) Social History:

Does your religion prohibit you from receiving blood products or blood transfusions? □ Yes □ No

*If yes, please be sure to discuss this with the doctor at the time of your evaluation.

Occupation: ______________________________

Do you or have you ever smoked? □ Yes □ No

□ 10/day □ 20/day □ 30/day □ 40/day If more please specify: ________/day

Age you started: ____________ Age you quit: ____________

Smokers in the home? □ Yes □ No If yes: □ Smokes Inside □ Smokes Outside

Do you drink alcohol? □ Currently □ Socially □ Occasionally □ Rare □ Never

Do you or have you ever used recreational drugs: □ Never □ Previously □ Currently

Exposure to loud noises? □ Yes □ No Specify: ______________________

8) Review of Systems: Please check any of the following symptoms you have.

Ears	**Nose**	**Throat**	**Other**
□ Hearing loss	□ Difficulty breathing	□ Sore throat	□ Shortness of breath
□ Ringing in ear	□ Allergies	□ Tonsillitis	□ Persistent Cough
□ Dizziness/vertigo	□ Nasal drainage	□ Snoring	□ Bloody sputum
□ Ear drainage	□ Nose bleeds	□ Apnea	□ Wheezing
□ Ear infections	□ Headaches	□ Difficulty Swallowing	□ Chest pain
□ Ear pain	□ Injury	□ Painful Swallowing	□ Heart Palpitations
□ Hole in eardrum	□ Sinusitis	□ Hoarseness	□ Ankle swelling
□ Speech delay		□ Neck masses/nodes	□ Stomach pain
		□ Thyroid problems	□ Indigestion
			□ Blood in bowel movement
			□ Frequent urination
			□ Painful urination
			□ Blood in urine
			□ Weight loss
			□ Fever

9) Family History: Please report significant family medical history in this section.

History:	**Family Member**:
□ Anesthesia Reaction	______________________________
□ Birth Defects (specify type)	______________________________
□ Bleeding/Clotting Difficulties	______________________________
□ Cancer (specify type)	______________________________
□ Diabetes (specify type)	______________________________
□ Hearing Loss	______________________________
□ Heart disease	______________________________