NAME:_____
D.O.B. ____/_____/_____/ AGE:_____
REFERRED BY:_____
PRIMARY CARE MD_____
HEIGHT:_____ WEIGHT_____

LOCAL PHARMACY COMMONLY USED AND PHONE# IF KNOWN:

DATE____/____/_____

I AM OVER 55 AND HAVE NOT HAD A RECENT HEARING TEST AND NEED ONE
I AM OVER 55 AND DO NOT WANT A HEARING TEST

MEDICAL HISTORY: CIRCLE ALL THAT APPLY: HYPERTENSION HEART ATTACK HEART ARRHYTHMIAS DIABETES ASTHMA BLEEDING TENDENCIES NEUROLOGIC DISORDERS SEIZURES STROKE COPD THYROID
OTHER:_____
_____
_____

LIST ALL PREVIOUS SURGERIES AND DATES IF KNOWN: TONSILLECTOMY/ ADENOIDECTOMY, SEPTOPLASTY, SINUS SURGERY, EAR TUBES,: OTHER
_____
_____
_____

LIST ALL MEDICATIONS, INCLUDING OVER THE COUNTER MEDS:_____
_____

SOCIAL HISTORY
SMOKE **N** **Y**, IF YES: HOW MANY PKS/DAY FOR HOW MANY YEARS_____
ALCOHOL INTAKE **N** **Y**, IF YES: HOW MUCH AND HOW OFTEN_____
PREVIOUS DRUG ABUSE **N** **Y**

ARE YOU **ALLERGIC** TO ANY MEDICATIONS?
PENICILLIN, SULPHA, ERYTHROMYCIN
OTHERS:

FAMILY HISTORY: PLEASE LIST ANY ILLNESS THAT RUN IN YOUR FAMILY:_____
_____
_____

ADDITIONAL MEDICAL HISTORY:_____
_____
_____
_____
_____
_____

CHECK ALL THAT APPLY:
__ EASY BRUISING
__ HEARING LOSS
__ TINNITUS/RINGING
__ VERTIGO
__ RECENT CHANGE IN VISION
__ NASAL OBSTRUCTION
__ NASAL BLEEDING
__ NASAL FRACTURE IN PAST
__ RECENT DENTAL WORK
__ RADIATION EXPOSURE
__ CANCER TREATMENTS
__ TROUBLE SWALLOWING
__ CHRONIC COUGH
__ CHRONIC HOARSENESS
__ SNORING
__ PULMONARY PROBLEMS
__ ARTHRITIS

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