

Patient Name: _____

Chart Number _____

DOB: ____/____/____

Neuro-otology Initial Visit (p. 1): Please provide the following medical information to the best of your ability:

Date: _____	Age: _____	List any ALLERGIES TO MEDICATIONS:
What problems are you here for today?		
Past Medical History:		
1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain		
	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>
Diabetes	<input type="checkbox"/> <input type="checkbox"/> _____	Stomach or Intestinal problems <input type="checkbox"/> <input type="checkbox"/> _____
Hypertension (high blood press)	<input type="checkbox"/> <input type="checkbox"/> _____	Allergy problems/therapy <input type="checkbox"/> <input type="checkbox"/> _____
Thyroid problems	<input type="checkbox"/> <input type="checkbox"/> _____	Kidney problems <input type="checkbox"/> <input type="checkbox"/> _____
Heart Disease/cholesterol probs	<input type="checkbox"/> <input type="checkbox"/> _____	Neurological problems <input type="checkbox"/> <input type="checkbox"/> _____
Respiratory problems	<input type="checkbox"/> <input type="checkbox"/> _____	Immune deficiency <input type="checkbox"/> <input type="checkbox"/> _____
Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/> _____	Other Medical Diagnosis <input type="checkbox"/> <input type="checkbox"/> _____
Hepatitis	<input type="checkbox"/> <input type="checkbox"/> _____	History of IV antibiotic treatment <input type="checkbox"/> <input type="checkbox"/> _____
2) Please list any operations (and dates) you have ever had (including tonsils & adenoids):		
3) Please list any current medications (and amounts, times per day);		
<i>including aspirin, antacids, vitamins, hormone replacement, birth control, herbal & weight control supplements, OTC nasal sprays/cold/sinus/allergy meds</i>		
Social History:		Please list details below:
	<u>Yes</u> <u>No</u>	
Do you currently smoke? List how much	<input type="checkbox"/> <input type="checkbox"/> _____	
If not smoking now, did you smoke previously?	<input type="checkbox"/> <input type="checkbox"/> _____	
How often do you drink alcohol? What kind?		_____
What is your occupation?		_____
Do you live alone?	<input type="checkbox"/> <input type="checkbox"/> _____	
Are you routinely exposed to loud noises?	<input type="checkbox"/> <input type="checkbox"/> _____	
Are you occasionally exposed to loud noises?	<input type="checkbox"/> <input type="checkbox"/> _____	
Have you been exposed to loud noises in the past?	<input type="checkbox"/> <input type="checkbox"/> _____	
Family History:		
Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:		
If yes, please indicate which relative(s) have the problem		
	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>
Hearing problems	<input type="checkbox"/> <input type="checkbox"/> _____	Heart problems <input type="checkbox"/> <input type="checkbox"/> _____
Dizziness	<input type="checkbox"/> <input type="checkbox"/> _____	Bleeding disorder <input type="checkbox"/> <input type="checkbox"/> _____
Neurological disorder	<input type="checkbox"/> <input type="checkbox"/> _____	Cancer <input type="checkbox"/> <input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> <input type="checkbox"/> _____	Anesthesia problems <input type="checkbox"/> <input type="checkbox"/> _____
Allergy	<input type="checkbox"/> <input type="checkbox"/> _____	
		Reviewed by: _____

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