Ear Institute of Chicago

11 Salt Creek Ln, Ste. 101
Hinsdale, IL 60521

800 Biesterfield Rd., Ste 4001
Elk Grove Village, IL 6007

PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

CHIEF CONCERN

Reason for today's visit: _____

PAST MEDICAL HISTORY

List any prior major illnesses: _____

SURGERIES/HOSPITALIZATIONS	DATE

MEDICATIONS (Name of medication only)

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.

DRUG ALLERGIES: _____

FAMILY HISTORY

(List family member and history of hearing loss, dizziness, migraine or acoustic tumor)

Family Member	Medical Condition

SOCIAL HISTORY

Occupation: _____

History of smoking?: No: ☐ Yes: ☐ If yes, for how long? _____

History of alcohol use ? : No: ☐ Yes: ☐ If yes, how often? _____

REVIEW OF SYSTEMS (Please check all items that pertain to you)

Allergic/Immunologic
Food allergies ☐
Immunologic Disorder ☐
Inhalant (nose) allergies ☐

Cardiovascular
Chest pain or angina ☐
Heart murmur ☐
Irregular pulse ☐
Leg Pain/Cramping while walking ☐
Palpitations ☐
Swelling in hands/feet ☐

Constitutional
Excessive fatigue ☐
Fever ☐
Night sweats ☐
Weight loss ☐

Dermatologic (Skin)
Skin cancer ☐
Skin disease ☐

Endocrine
Excessive thirst ☐
Excessive urination ☐
Hormone problems ☐
Increased appetite ☐

Ear, Nose, Throat
Dizziness:
- Floating Sensation ☐
- Lightheadedness ☐
- Spinning ☐
- Unsteadiness ☐

Ear drainage ☐
Ear fullness ☐
Ear pain ☐
Hearing loss ☐
Inability to smell ☐
Mouth sores ☐
Nasal congestion ☐
Nasal drainage ☐
Nose bleeds ☐
Ringing (Noise) in the Ear(s):
Left ☐ Right ☐ Both ☐
Sore Throat ☐

Gastroenterology
Abdominal pain ☐
Change in bowel habits ☐
Colon cancer ☐
Nausea ☐
Ulcers or Gastritis ☐
Vomiting ☐

Hematologic/Lymphatic
Anemia ☐
Bleeding tendency ☐
Hemophilia ☐

Musculoskeletal
Arthritis ☐
Back Pain ☐
Broken bones ☐
Joint pain ☐
Joint swelling ☐

Neurological
Difficulty with speech ☐
Disorientation ☐
Facial numbness ☐
Facial twitching ☐
Facial weakness ☐
Fainting spells or blackouts ☐
Inability to concentrate ☐
Memory problems ☐
Migraine headaches ☐
Problems with coordination ☐
Seizures ☐
Tingling of feet ☐
Tingling of hands ☐

Ob/Gynecology
Currently Pregnant ☐
Breast cancer ☐
Cervical cancer ☐
Uterine cancer ☐

Ophthalmology (Eyes)
Diminished vision ☐
Double vision ☐
Eye inflammation ☐

Psychiatric
Anxiety ☐
Depression ☐
Sleep disturbance ☐
Suicidal thoughts ☐

Respiratory
Lung cancer ☐
Shortness of breath ☐
Wheezing ☐

Urology
Blood in urine ☐
Difficulty urinating ☐
Kidney stones ☐
Prostate cancer ☐

The above information is accurate to the best of my knowledge:

Patient (or Guardian) Signature:_____ Date:_____

The above information has been reviewed with the patient and is deemed correct:

Physician:_____ Date:_____