

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

PATIENT HEALTH HISTORY

Patient Name: Date of Birth:

CHIEF CONCERN

Reason for today's visit:

PAST MEDICAL HISTORY (please check all that apply)

Asthma <input type="checkbox"/>	Acoustic Neuroma <input type="checkbox"/>	Emphysema <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Migraine Headache <input type="checkbox"/>	Rheumatoid Arthritis <input type="checkbox"/>
Heart Disease <input type="checkbox"/>	Sarcoidosis <input type="checkbox"/>	Thyroid Disorder <input type="checkbox"/>
High Blood Pressure <input type="checkbox"/>	Seizures <input type="checkbox"/>	Other Condition(s): <input type="text"/>
Cancer <input type="checkbox"/> Type: <input type="text"/>		<input type="text"/>
<input type="text"/>		<input type="text"/>

SURGERIES/HOSPITALIZATIONS

DATE

SURGERIES/HOSPITALIZATIONS	DATE

MEDICATIONS (Name of medication only)

1. <input type="text"/>	2. <input type="text"/>	3. <input type="text"/>
4. <input type="text"/>	5. <input type="text"/>	6. <input type="text"/>
7. <input type="text"/>	8. <input type="text"/>	9. <input type="text"/>
10. <input type="text"/>	11. <input type="text"/>	12. <input type="text"/>

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, do you still smoke? No: Yes:

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 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:
Both Right Left
Ringing (Noise) in the Ear(s):
Both Right Left
Nasal congestion
Nasal drainage

Gastroenterology

Abdominal pain
Change in bowel habits
Nausea
Ulcers or Gastritis
Vomiting

Hematologic/Lymphatic

Anemia
Bleeding tendency
Hemophilia

Musculoskeletal

Arthritis
Back Pain
Broken bones

Neurological

Difficulty with speech
Facial numbness
Facial twitching
Facial weakness
Fainting spells or blackouts
Inability to concentrate
Memory problems
Tingling of feet
Tingling of hands

Ob/Gynecology

Currently Pregnant

Ophthalmology (Eyes)

Diminished vision
Double vision
Eye inflammation

Psychiatric

Anxiety
Depression
Sleep disturbance
Suicidal thoughts

Respiratory

Shortness of breath
Wheezing

Urology

Blood in urine
Difficulty urinating
Kidney stones

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

Patient (or Guardian) Signature: _____ Date: _____