Ear Institute of Chicago
11 Salt Creek Ln., Ste. 100
Hinsdale, IL 60521

AdventHealth Medical Group

PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

CHIEF CONCERN

Reason for today's visit: _____

PAST MEDICAL HISTORY (please check all that apply)

Asthma ☐
Diabetes ☐
Heart Disease ☐
High Blood Pressure ☐
Cancer ☐ Type: _____

Acoustic Neuroma ☐
Migraine Headache ☐
Sarcoidosis ☐
Seizures ☐

Emphysema ☐
Rheumatoid Arthritis ☐
Thyroid Disorder ☐
Other Condition(s): _____

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, 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: