EAR·NOSE·THROAT SPECIALISTS
of Northern Virginia, P.C.

PROFESSIONAL HEARING SERVICES
The Dizziness and Balance Center
The Hearing Aid Center

HEALTH HISTORY

Patient Name ________________________________ D.O.B. ______ / ______ / ______ Age ____________________________

Reason for Visit ______________________________

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

VITALS: Height: ______ Ft ______ In Weight: ______ Lbs (Office Use Only) Bp: ______ Pulse: ______

1. Past Medical History – Have you ever had the following: ☐ No Significant Past Medical History

☐ Allergic Rhinitis
☐ Arthritis
☐ Asthma
☐ Autoimmune Disorder
☐ Cancer (Type) ________________
☐ Cerumen (Wax)
☐ Cholesteatoma
☐ Deviated Nasal Septum
☐ Diabetes
☐ Eczema
☐ Elevated Cholesterol
☐ Epistaxis
☐ HIV
☐ Hearing Loss
☐ Head Injury
☐ Heart Attack
☐ Hypertension
☐ Meniere's Disease
☐ Middle Ear Inf
☐ Migraines
☐ Nasal Injury
☐ Nasal Polyps
☐ Pharyngitis
☐ Sleep Apnea
☐ Sinusitis
☐ Snoring
☐ Stroke
☐ TMJ
☐ Thyroid Dis
☐ Tonsillitis
☐ Other ____________________

2. Past Surgical History – Have you ever had the following: ☐ No Significant Past Medical History

☐ Sinus Surgery ☐ Tonsil /Adenoid ☐ Ear Surgery ☐ Ear Tubes ☐ Thyroid/Neck Surgery
☐ Vocal/Larynx Surgery ☐ Cervical Spine Surgery ☐ Other ____

3. **Current Medications:** *(Including over the counter) strength and dosage* ☐ No Medications

____

____

____

4. Please list all Allergies: *(food, drugs, environment)* ☐ No Allergies

____

____

____

5. Family History: *(food, drugs, environment)* ☐ No Family History of Problems

Relationship	Relationship
☐ Cancer ______________________	What type of cancer? ______________________
☐ Neurology Disorder ______________________	☐ Diabetes ______________________
☐ Hearing Loss ______________________	☐ Stroke ______________________
☐ Heart Disease ______________________	☐ Kidney Problems ______________________
☐ Hypertension ______________________	☐ Bleeding Problems ______________________

6. Social History:

Occupation ____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Tobacco: ☐ Never ☐ Former Smoker (quit ____ yrs ago) ☐ Active everyday (____ packs/day x ____ yrs) ☐ Minimal

Alcohol: ☐ Never ☐ Social ☐ less than 10 per week ☐ more than 10 per week

7. Review of Systems: *Please mark the symptoms you currently have or had within the past 6 months.*

Constitutional

☐ fever ☐ fatigue ☐ poor appetite

Eyes

☐ vision change ☐ dry eyes ☐ excessive tearing

HENT

☐ headache ☐ vertigo ☐ dizziness
☐ dental problems ☐ ear pain ☐ hearing loss
☐ ringing in ears ☐ pulse in ear ☐ ear discharge
☐ pressure in ear ☐ itching in ear ☐ nasal congestion
☐ nose bleeding ☐ sinus pain ☐ postnasal drip
☐ decreased smell ☐ runny nose ☐ nasal obst
☐ sore throat ☐ mouth ulcers ☐ enlarged tonsils
☐ hoarseness ☐ lump in throat ☐ white spots in mouth

Cardiovascular

☐ chest pain ☐ syncope ☐ irregular heartbeats

Respiratory

☐ wheezing ☐ snoring ☐ shortness of breath

Gastrointestinal

☐ nausea ☐ heartburn ☐ difficulty swallowing
☐ excessive belching

Integument

☐ rash ☐ dry skin ☐ itching

Neurological

☐ seizure ☐ tremors ☐ tingling or numbness
☐ muscular weakness ☐ memory loss

Musculoskeletal

☐ back pain ☐ joint pain ☐ neck pain
☐ swelling

Endocrine

☐ weight gain ☐ weight loss ☐ cold intolerance
☐ hot intolerance

Psychiatric

☐ anxiety ☐ depression

Blood-Lymph

☐ easy bleeding ☐ easy bruising ☐ swollen glands

Allergic-Immunologic

☐ food allergies ☐ frequent illness ☐ environmental allergies

____ ____________________

Signature of Patient or Responsible Party Date