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

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

REVIEW OF SYMPTOMS

Patient Name: _____ DOB: _____ / _____ / _____ Age: _____

Reason for Visit: _____

To help us meet all your health care 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	☐ Diabetes	☐ Hypertension	☐ Sinusitis
☐ Arthritis	☐ Eczema	☐ Meniere's Disease	☐ Snoring
☐ Asthma	☐ Elevated Cholesterol	☐ Middle Ear Inf	☐ Stroke
☐ Autoimmune Disorder	☐ Epistaxis	☐ Migraines	☐ TMD
☐ Cancer (type) _____	☐ HIV	☐ Nasal Injury	☐ Thyroid Disorder
☐ Cerumen (wax)	☐ Hearing Loss	☐ Nasal Polyps	☐ Tonsillitis
☐ Cholesteatoma	☐ Head Injury	☐ Pharyngitis	☐ Other _____
☐ Deviated Nasal Septum	☐ Heart Attack	☐ Sleep Apnea	

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 ____ years ago) ☐ Active everyday (____ packs/day x ____ years) ☐ Minimal

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

_____

Patient or Responsible Party (printed)

_____ _____

Signature of Patient or Responsible Party Date