

Ear Institute of Chicago, LLC

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PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

CHIEF CONCERN

Reason for today's visit: _____

PAST MEDICAL HISTORY

Please list any prior major illnesses and/or injuries: _____

SURGERIES/HOSPITALIZATIONS

YEAR

SURGERIES/HOSPITALIZATIONS	YEAR

MEDICATIONS (List Name, dosage and frequency)

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

DRUG ALLERGIES: _____

FAMILY HISTORY

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

SOCIAL HISTORY

Occupation: _____

History of smoking?: No ___ Yes ___ If yes, what type and for how long? _____

History of alcohol use: No ___ Yes ___ How often? _____

REVIEW OF SYSTEMS (Please circle all items for which you have had problems)

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 and/or 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

Breast cancer
Cervical cancer
Pregnancy
Uterine cancer

Ophthalmology (Eyes)

Blurred vision
Diminished vision
Double vision
Eye inflammation

Psychiatric

Anxiety
Depression
Sleep disturbance
Suicidal thoughts

Respiratory

Chronic cough
Lung cancer
Shortness of breath
Wheezing

Urology

Blood in urine
Dialysis
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: _____