hearflorida

□ Neuro-Audiology Consultants
□ Miami Hearing and Speech Center
□ Audiology Consultants of Boynton Beach, Inc.

PATIENT HISTORY

Patient Name_____ Today's Date_____

Reason for Today's Visit (One sentence or less)_____

_____

Brief History of the Problem (When did it begin? What are the symptoms? Does anything make it better or worse? Have any medications been tried, etc?)_____

_____

_____

Systems Review (Indicate any medical problems related to each of the following)

Ears:
O No Problems
O Decreased Hearing
O Fluid
O Ear Pain
O Drainage/Discharge
O Imbalance/Dizziness
O Tinnitus or Head Noise
O Wax Build-up
O Other_____

Nose:
O No Problems
O Allergy
O Blocked Breathing
O Infections/Sinusitis
O Nosebleeds
O Other_____

Mouth:
O No Problems
O Mouthbreathing
O Sleep Apnea/Snoring
O Tonsil & Adenoid Enlargement
O Tonsillitis
O History of Tonsillectomy
O TMJ Dysfunction
O Other_____

Throat:
O No Problems
O Difficulty Swallowing
O Hoarseness
O Other_____

Neck:
O No Problems
O Enlarged/Tender Glands
O Neck Mass
O Other_____

Eyes:
O No Problems
O Cataracts
O Glaucoma
O Other_____

Heart:
O No Problems
O Heart Attack/Surgery
O High Blood Pressure
O Other_____

Lungs:
O No Problems
O Asthma/Wheezing
O Emphysema
O Tuberculosis
O Other_____

Breasts:
O No Problems
O Cancer
O Other_____

Stomach:
O No Problems
O Ulcer/Colitis
O GERD
O Hiatal Hernia
O Other_____

Urinary:
O No Problems
O Kidney Disease
O Prostate Disease
O Other_____

OB/GYN:
O No Problems
O Pregnant/Planning
O Other_____

Endocrine/ Hormones:
O No Problems
O Diabetes
O Thyroid Problem
O Other_____

Muscles/ Joints:
O No Problems
O Arthritis
O Other_____

OVER »

Skin: O No Problems
O Other_____

Blood & Lymph System: O No Problems
O Anemia
O Bleeding Disorder
O Hepatitis
O High Cholesterol
O Immune Disorder/HIV
O Leukemia
O Other_____

Neurologic: O No Problems
O ADD/ADHD
O Developmental Delay(s)
O Down Syndrome
O Numbness/Weakness
O Seizures
O Other_____

Psychiatric: O No Problems
O Depression
O Drug/Alcohol Dependent
O Other_____

Past History

Allergies to Medications: O None O List:_____
Allergies to Food: O None O List:_____
Current Medications: O None O List:_____
_____
Chemotherapy in Past: If yes, list medications:_____
Hospitalizations: O None If yes list reasons:_____
Surgeries: O None If yes list:_____
Vaccinations/Immunizations: Childhood Up to date: O Yes O No (why ?)_____
O Tetanus Shot Date_____ O Flu Shot Date_____Hepatitis B: O Yes O No
Birth History: O Normal Birth weight:____lbs____oz O Premature? If yes, how early?_____ O Jaundice O Transfusion O Prolonged Hospitalization/NICU

Family History

Patients Mother: O Alive O Healthy O If not describe_____
O Deceased (at what age?)_____ Cause?_____
Patients Father: O Alive O Healthy O If not describe_____
O Deceased (at what age?)_____ Cause?_____
List family members with hearing loss:_____
Is patient adopted? O Yes O No

Social History

Occupation:_____
If retired, former occupation:_____
Work exposure to: Loud Noise O Yes O No
Smoke Fumes: O Yes O No
Highest level of education:_____ Hobbies:_____

Smoking: Current: O No If yes, packs per day:_____ For how many years?____
Past: O Quit (when?)____ Packs per day:_____ For how many years?____
Alcohol use: O None If yes, how much daily: Beer:____ Wine:____Other:_____
Drug use: O None If yes, cocain? O Other?_____

For Office Use Only

Hx reviewed and discussed by & date: / /