Patient Medical Questionnaire (front & back)

Carolina Ear & Hearing Clinic, PC ★

Patient Name:	Date:

1. What is the reason for your visit today?

2. What treatment have you received for this condition?

3. Please list your other health care providers (primary care, ENT, ect) :

How much is your hearing loss affecting your daily life? (circle a number)

Very little 1 2 3 4 5 6 7 8 9 10 Very much

Medical History/Review of Systems

4. How would you rate your general health?

5. The following is a list of common symptoms and health problems. Please review the list and check the box if you are currently experiencing or have ever had/been diagnosed with any of these symptoms and/or health problems.

- ☐ Allergies/Hay Fever
- ☐ Anemia/Bleeding Disorder
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/Chronic Lung Disease
- ☐ Bloody Nose
- ☐ Blurry/Double Vision
- ☐ Bowel Irregularity
- ☐ Cancer/Tumors
- ☐ Cataracts
- ☐ Chest Pain
- ☐ Chronic Fatigue Syndrome
- ☐ Daytime Sleepiness
- ☐ Decreased Energy
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Ear Infections/Chronic
- ☐ Eye Pain
- ☐ Facial Pain Fevers/Chills
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hoarseness/Voice Problems
- ☐ Immunodeficiency
- ☐ Kidney Disease
- ☐ Meningitis/Encephalitis
- ☐ Migraine Headache
- ☐ Mitral Valve Prolapse
- ☐ Muscle Aches
- ☐ Muscle/Skeletal Problems
- ☐ Nausea/Vomiting
- ☐ Numbness
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Prostate Problems
- ☐ Radiation Therapy
- ☐ Ringing in the Ears
- ☐ Runny Nose
- ☐ Seizures/Epilepsy
- ☐ Sinus/Nasal Pain/Disease
- ☐ Skin Problems/Rashes
- ☐ Sore Throat
- ☐ Stroke
- ☐ Syncope/Fainting Spells
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Weight Gain/Loss

7 A. Please list your previous surgical procedures.

Did you experience any difficulty with anesthesia?
Did you experience any bleeding problems following surgery?

7 B: If you have a Cardiologist, please list name of Physician and practice:

8 Please list your previous injuries or accidents:

- ☐ To the ear and/or head
- ☐ Noise Exposure
- ☐ Other

9. Are you disabled in any way or have any birth defects?

If yes, please describe.

10. Are you allergic to any medications?

- ☐ Yes
- ☐ No

If yes, please list and explain your reaction to this medication

11. Are you currently taking any medication that may affect blood clotting (i.e., Coumadin)? Please list these medications.

12. Please list your current medications (or attach a complete list that we may keep). **Please include all prescription and over-the-counter medications, vitamins, herbal supplements, etc.** Use the back of this page if necessary.

Medication Name	Dosage (mg, ml, etc)	Frequency (how often)	Route of Administration

13. Have you received/taken any of the following:
- ☐ Prolonged use of IV antibiotics (given by vein)
- ☐ Chemotherapy agents for cancer
- ☐ High doses of aspirin (more than 8 per day)
- ☐ Quinine for malaria
- ☐ Diuretics (water pills)
- ☐ Cortisone

If yes to any of these, please explain usage.

14. A. Have you received any alternative treatments or medical care (acupuncture, chiropractic, etc.)?
- ☐ Yes
- ☐ No

If yes, please specify type of care and for what reason.

14 B. Have you received your influenza vaccination this year? If so, when?
_____

14 C. Have you received your pneumococcal vaccination this year? If so, when? _____

15. Do you or have you had any other medical problems not listed above:
- ☐ Yes
- ☐ No

If yes, please give details.

Family History

16. Do any of your family members have any of the following conditions?

☐ Allergies	☐ Cancer	☐ Heart Disease
☐ Asthma	☐ Cystic Fibrosis	☐ Immunodeficiency
☐ Anemia/Bleeding Disorder	☐ Ear Problems/Hearing Loss	☐ Other

Social History

17. What is your current or previous occupation?

18. Do you smoke or use E cigarettes?
- ☐ Yes
- ☐ No
- ☐ Previously

If yes, how much?
If previously, when did you quit?

19. Describe your diet:
- ☐ Regular
- ☐ Special

Please explain any special diet.

20. Do you drink alcoholic beverages?
- ☐ Yes
- ☐ No

If yes, what type and how much?

21. Do you exercise?
- ☐ Yes
- ☐ No

If yes, what type and how often?

22. Do you drink caffeine (coffee, tea, soda)?
- ☐ Yes
- ☐ No

If yes, what type and how much?

23. Have you had any recent changes in your home or work environment?
- ☐ Yes
- ☐ No

If yes, please give details.