



New Adult Patient Health History

Name: _____ Date of Birth: _____ Date: _____

Preferred Pharmacy: _____ Height: _____ Weight: _____

Email: _____ Preferred Language: _____

Race: _____ Ethnicity (Circle one): Hispanic Non-Hispanic Other _____

Please list family members that are patients or have been seen in our office: _____

Please answer the following the best you can. Some of these may be difficult to answer and the medical staff will assist you when you are brought to the exam room. Anything left blank will be assumed normal / not present.

What is the reason for today's visit? _____

Do you have a history of hearing loss or difficulty? Yes No Tinnitus (ringing or buzzing in ears)? Yes No

Where is the location of the problem? _____

How often does it occur? How long has it occurred? _____

Is it painful? If so, please explain: _____

Is it getting worse, improving, or staying the same? _____

What are some things that make it better or worse? _____

Other symptoms: _____

Do you take any blood thinning medications or Aspirin? Yes No If yes, please list: _____

MEDICATIONS:

List all prescription and nonprescription medicines, or provide list.

Medicine	Dose	How often
Example: Aspirin	81 mg	once a day

ALLERGIES / SENSITIVITIES

Penicillin Allergy? No Yes. Reaction: _____

Environmental? No Yes: _____

Other Medication Allergies **Side Effects/Reaction**

SOCIAL HISTORY

Occupation: Working: _____ Retired Unemployed N/A

Are you under an excessive amount of stress? Yes No N/A

NO Tobacco Exposure YES Tobacco Exposure: (Circle all that apply) Tobacco Smokeless Other: _____

Age began _____ Years Smoked _____ Average pack per day _____ Age quit _____

Alcohol use? Yes No If yes: number of drinks per week: _____

Drugs use? Yes No If yes: please describe: _____

Please complete both front and back of this questionnaire.

PAST SURGICAL / MAJOR ILLNESS HISTORY (List as accurately as possible what, when, and why.)

1. _____
2. _____
3. _____
4. _____

FAMILY HISTORY – Do any of your family members have the following?

	YES	NO	RELATIONSHIP	EXPLAIN
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Respiratory failure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anesthetic complications	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other inherited diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

PATIENT MEDICAL HISTORY – Pertaining only to the patient

	YES	NO	EXPLAIN
Anesthetic complications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye penetrating injury involving metal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin changes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, Nose, Throat problems (unrelated to today's visit)	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of fever, weight loss or chills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visual Changes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing problems or ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of noise exposure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you pregnant (women only)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular problems (ex: Heart attack, chest pain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (ex: Asthma, wheezing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (ex: Bloody stools, ulcers)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary problems (ex: Painful, bloody urination)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problem (ex: Arthritis) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological problems (ex: Stroke, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (ex: Depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine problems (ex: Diabetes, low thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immune problems (ex: AIDS, immune deficiencies)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Signature _____