HAWAII EAR CLINIC, INC.

Name: _____ Date: _____

CHIEF COMPLAINTS / HISTORY OF ILLNESS:

1. What is the reason for today's visit? _____
2. How long have you had this problem? _____
3. How severe is this problem? (*Circle)* 1*(Mild)*2 3 4 5 6 7 8 9 10 *(Severe)*
4. How often does this problem occur? _____
5. What makes it better? _____
6. What makes it worse? _____
7. What other symptoms are you having? _____

PAST MEDICAL HISTORY *(Please check any illnesses you have)*:

□ High Blood Pressure □ Asthma/Emphysema □ Prostate removal □ Kidney disease
□ Stroke, mini stroke □ Sinusitis □ Diabetes □ Heart disease/Angina
□ Peptic Ulcers □ Neck/Back disease □ Thyroid disease □ Hepatitis/Liver disease
□ Cancer (please list type & date diagnosed): _____
□ Chest x-ray: _____ □ Other: _____ □ No Past Medical History

PAST SURGICAL HISTORY *(Please check any surgeries you have had)*:

□ Heart bypass/valve □ Gall bladder □ Prostate Removal □ Mastectomy
□ Coronary angioplasty □ Lung surgery □ Back surgery □ Joint replacement
□ Carotid artery surgery □ Colon removal □ Brain surgery □ Appendix removal
□ Transplant surgery □ Ear Surgery □ Sinus surgery □ Colonoscopy
□ Vascular bypass □ Hysterectomy □ Tonsillectomy □ No Previous Surgery
□ Transplant: _____ □ Other: _____

MEDICATIONS *(List all your current medications & the dose you take or submit a list)*:

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Do you take Aspirin or Ibuprofin? □ Yes □ No Do you take Warfarin (Coumadin)? □ Yes □ No
Have you taken steroids within the past year? □ Yes □ No □ No current Medications

ALLERGIES *(List medications/foods you are allergic to & the reaction which occurs)*:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____
□ No Known Allergies

SOCIAL HISTORY:

Occupation: _____ Marital Status: □ Married □ Single □ Divorced □ Widowed □ Partner
Children: □ Yes □ No How many? _____
Have you ever smoked? □ Yes □ No (□ cigarettes □ cigar □ pipe) When did you quit? _____
If yes, how much and for how long have you smoked? _____ packs per day for _____ years.
Do you drink alcohol? □ Yes □ No How much alcohol do you drink each day? _____
Do you have any drug addictions? □ Yes □ No List any street drugs you currently use: _____

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REVIEW OF SYSTEMS *(Check all symptoms you have had either now or in the past):*

EYES:
□ Double vision
□ Loss of vision
□ Eye pain
□ Not to my knowledge

ENT:
□ Hearing loss
□ Ringing in ears
□ Dizziness
□ Headaches
□ Ear pain
□ Ear drainage
□ Facial pain
□ Voice change
□ Nasal drainage
□ Nasal congestion
□ Poor sleep
□ Snoring
□ Swallowing pain
□ Hoarseness
□ Sore mouth/throat
□ Not to my knowledge

□ Weight loss _____ pounds in the past _____ weeks
□ Fever, chills
□ Not to my knowledge

CARDIOVASCULARY/PULMONARY:
□ Chest pain
□ Heart attack
□ Irregular heartbeat
□ Poor circulation
□ Coughing up blood
□ Shortness of breath
□ Asthma
□ Leg pain while walking
□ Not to my knowledge

GASTROINTESTINAL:
□ Stomach ulcers
□ Nausea/vomiting
□ Diarrhea
□ Blood in stool
□ Abdominal pain
□ Trouble swallowing
□ Heartburn/Reflux
□ Not to my knowledge

GENITOURINARY:
□ Dialysis
□ Blood in urine
□ Pain during urination
□ Difficulty making urine
□ Not to my knowledge

MUSCULOSKELETAL:
□ Arthritis
□ Neck/Spine surgery
□ Neck or Back disorder
□ Not to my knowledge

NEUROLOGICAL:
□ Stroke
□ Mini-stroke
□ Loss of sensation
□ Facial paralysis
□ Paralysis of an arm or leg
□ Temporary loss of vision or speech control
□ Not to my knowledge

SKIN:
□ Skin cancers
□ Eczema
□ Rash
□ Itching
□ Not to my knowledge

ALLERGIC/IMMUNOLOGIC:
□ Environmental allergy
□ Immunosuppression
□ Medical tape, iodine, or latex
□ Not to my knowledge

PSYCHIATRIC:
□ Anxiety
□ Bipolar Disorder
□ Clinical depression
□ Schizophrenia
□ ADHD
□ Autism
□ Other: _____
□ Not to my knowledge

INFECTIOUS DISEASE:
□ Hepatitis
□ HIV/AIDS
□ TB
□ Mononucleosis
□ Not to my knowledge

HEMATOLOGIC:
□ Easy bleeding
□ Easy bruising
□ Enlarged lymph nodes
□ Not to my knowledge

ENDOCRINE:
□ Menopause
□ Temperature intolerance
□ Excessive Urination
□ Not to my knowledge

MISC:
□ Down Syndrome
□ Congenital Abnormalities
□ Other: _____

FAMILY HISTORY *(Check all illnesses that are in your immediate family blood line)*:

□ Hearing loss
□ Heart Attack
□ Diabetes
□ Alcoholism
□ High blood pressure
□ Bleeding problems
□ Sickle cell anemia
□ Stroke
□ Poor circulation
□ Anesthesia reaction
□ Psychiatric illness
□ Cancer: _____
□ Not to my knowledge

I agree that the questions which I have answered have been completed to the best of my knowledge:

_____ _____
Patient or Legal Guardian Signature *Date*

_____ _____
Attending Physician's Signature *Date*