If you have completed sections 1-4 since your last birthday, please proceed to section 5. Check all that apply.

1. Medical History
- Anemia
- Anxiety
- Arthritis
- Asthma
- Bleeding Disorder
- Blood Clots/DVT
- Cancer
- CHF/Heart Failure
- Depression
- Diabetes
- Emphysema/COPD
- GERD/Heartburn/Acid Reflux
- Heart Disease
- HIV/AIDS
- Hypertension/High Blood Pressure
- Kidney Disease
- Liver Disease
- Palpitations/Racing Heart
- Seizures
- Stroke
- Thyroid Problems
- Other

2. Surgical History
- No surgery
- Anesthesia Complications
- Appendectomy
- Breast surgery
- Colonoscopy
- Coronary Artery Bypass
- Coronary Artery Stent
- Eye Surgery
- Gallbladder Surgery (Cholecystectomy)
- Hernia repair
- Hip Replacement
- Hysterectomy
- Knee Replacement
- Prostate Surgery
- Spine Surgery
- Organ Transplant
- Other

3. Social History
- Alcohol Use
  - Yes
  - No
  - Never
  - Wine
  - Beer
  - Liquor
- Street Drug Use
  - Yes
  - No
  - Never
  - Marijuana
  - Methamphetamines
  - Cocaine
  - Heroine
  - Other
- Tobacco Use
  - Yes
  - No
  - Never
  - Current Smoker
  - Packs per day _____
  - Former Smoker
- Sexually Active
  - Yes
  - No
  - Not Currently
  - Partners
- Check all that apply
  - Female
  - Male
  - Birth Control / Protection
  - Yes
  - No
  - Method _________________

4. Family Medical History Check all that apply.
- I have no family history
- I have unknown family history

| Relationship          | Anemia | Anxiety | Arthritis | Asthma | Bleeding Disorder | Blood Clots / DVT | Cancer | CHF/Heart Failure | Depression | Diabetes | Emphysema/COPD | GERD/Heartburn/Acid Reflux | Heart Disease | HIV/AIDS | High Blood Pressure | Kidney Disease | Liver Disease | Palpitations/Racing Heart | Seizures | Stroke | Thyroid Problems |
|-----------------------|--------|---------|-----------|--------|-------------------|-------------------|-------|-------------------|------------|----------|                |                           |              |          |                  |                |              |                         |          |        |                   |          |        |                 |
| Father                |        |         |           |        |                   |                   |       |                   |            |          |                  |                           |              |          |                  |                |              |                         |          |        |                   |          |        |                 |
| Mother                |        |         |           |        |                   |                   |       |                   |            |          |                  |                           |              |          |                  |                |              |                         |          |        |                   |          |        |                 |
| Sibling               |        |         |           |        |                   |                   |       |                   |            |          |                  |                           |              |          |                  |                |              |                         |          |        |                   |          |        |                 |
| Maternal Grandmother |        |         |           |        |                   |                   |       |                   |            |          |                  |                           |              |          |                  |                |              |                         |          |        |                   |          |        |                 |
| Maternal Grandfather  |        |         |           |        |                   |                   |       |                   |            |          |                  |                           |              |          |                  |                |              |                         |          |        |                   |          |        |                 |
| Paternal Grandmother  |        |         |           |        |                   |                   |       |                   |            |          |                  |                           |              |          |                  |                |              |                         |          |        |                   |          |        |                 |
| Paternal Grandfather  |        |         |           |        |                   |                   |       |                   |            |          |                  |                           |              |          |                  |                |              |                         |          |        |                   |          |        |                 |
| Other                 |        |         |           |        |                   |                   |       |                   |            |          |                  |                           |              |          |                  |                |              |                         |          |        |                   |          |        |                 |
If you have completed sections 1-4 since your last birthday, please proceed to section 5.

5. Otolaryngology History

Reason for today’s visit? ________________________________________________________________

What treatment have you received for this? _______________________________________________

Check all symptoms that apply.

☐ Fevers ☐ Ear Pain ☐ Runny Nose ☐ Muscle Aches
☐ Chills ☐ Ear Drainage ☐ Stuffy Nose ☐ Heartburn
☐ Weight Loss ☐ Nosebleeds ☐ Sinus Pain ☐ Upset Stomach
☐ Tired ☐ Congestion ☐ Snoring ☐ Gland Swelling
☐ Rash ☐ Sneezing ☐ Dry Mouth ☐ Tremor
☐ Itching ☐ Light Sensitivity ☐ Blurry Vision ☐ Depression
☐ Headaches ☐ Sore Throat ☐ Watery, Itchy Eyes ☐ Nervousness/Angy
☐ Dizziness ☐ Hoarse Voice ☐ Double Vision ☐ Daytime Sleepiness
☐ Hearing Loss ☐ Cough ☐ Eye Pain ☐ Numbness
☐ Ringing in Ears ☐ Shortness of Breath ☐ Chest Pain

Does anyone in your family have hearing loss?  □ Yes  □ No

If yes, how are they related? □ Parent  □ Grandparent  □ Sibling  □ Children  □ Aunt  □ Uncle  □ Cousin  □ Other

Is there any other information you would like us to know?