EAR CENTER NORTHWEST
Otology • Neurotology
Medicine and Surgery of the Ear

Seattle and Bellevue
TEL 206-838-9595
FAX 206-682-3012
www.earcenternw.com

MEDICAL HISTORY

Dick Hoistad, MD, FACS
Constantine W. Palaskas, MD

Reason For Today's Visit ______________________

Onset of Symptoms ______________________

MEDICATIONS ☐ **No Medications**

List any medications (with dosage) you are presently taking.

1.
2.
3.
4.
5.
6.
7.
8.

ALLERGIES ☐ No Allergies

Please list any medications you have had an allergic reaction to and the type of reaction.

Medication	*Reaction*

Have you been ***diagnosed*** with and/ or treated for any of the following **MEDICAL PROBLEMS/CONDITIONS**? Please review each section and check "None" if none apply.

ENT
☐ **None**

Ear:
☐ Hearing Loss ☐ Hearing Aids
☐ Tinnitus
☐ Ear Infections
☐ Meniere's Disease
☐ Positional Vertigo
☐ Labyrinthitis
☐ Other

Nose:
☐ Sinusitis ☐ Deviated Septum
☐ Seasonal Allergies

Throat:
☐ Tonsillitis ☐ Voice Disorder
☐ TMJ

CARDIOVASCULAR
☐ **None**
☐ High Blood Pressure
☐ Heart Murmur
☐ Heart Attack
☐ Coronary Artery Disease
☐ Congestive Heart Failure
☐ Abnormal Heart Rhythm
☐ High Cholesterol

RESPIRATORY
☐ **None**
☐ Emphysema/COPD
☐ Asthma
☐ Tuberculosis
☐ Sleep Apnea

GI
☐ **None**
Hepatitis ☐A ☐B ☐C
☐ Liver Dysfunction
☐ Reflux/GERD
☐ Peptic Ulcer

RENAL
☐ **None**
☐ Renal Dysfunction
☐ Bladder Problems

NEURO
☐ **None**
☐ Seizure Disorder
☐ Stroke
☐ Bell's Palsy
☐ Peripheral Neuropathy

PSYCH
☐ **None**
☐ Depression
☐ Anxiety Disorder

HEMATOLOGIC ☐ **None**
☐ Anemia
☐ Clotting Problems
☐ HIV+ ☐ AIDS

METAB/ENDO
☐ **None**
☐ Diabetes
☐ Thyroid Problems

MUSCULOSKELETAL
☐ **None**
☐ Neck/Back Problems
☐ Arthritis
☐ Artificial Joints

Other Medical Conditions for which you are being followed or treated:

SURGERIES ☐ **No Surgeries**

1.
2.
3.
4.

Patient Label

rev 02052009

MEDICAL HISTORY

INJURY AND EXPOSURE

☐ Occupational or other Noise Exposure. Please describe:

☐ Nasal Fracture ☐ Neck Injury ☐ Head Injury with ☐ Loss of Consciousness

FAMILY HISTORY

☐ Early Hearing Loss ☐ Cancer ☐ Diabetes ☐ Stroke ☐ Coronary Disease

☐ Bleeding Disorders ☐ High Blood Pressure

SOCIAL HISTORY

Occupation:

☐ Alcohol ☐ Tobacco Smoke_____ #Years_____ Packs/Day_____ ☐ Caffeine _____/day ☐ Recreational Drugs

REVIEW OF SYSTEMS

Are you presently or frequently bothered by any of the following **SYMPTOMS**?

ENT -

***Ear*:** ☐ **None** ☐ Hearing Loss ☐ Ringing In Ears/Head Noise ☐ Ear Infections ☐ Ear Drainage
☐ Ear Pain ☐ Balance Disturbance (Dizziness, Spinning)

***Nose*:** ☐ **None** ☐ Nasal Obstruction ☐ Inability To Smell ☐ Frequent Nose Bleeds ☐ Runny Nose ☐ Facial Pain

***Throat*:** ☐ **None** ☐ Tonsillitis ☐ Sore Throat ☐ Difficulty Swallowing ☐ Voice Problems ☐ Dental Problems

GEN ☐ **None** ☐ Fever ☐ Night Sweats ☐ Excessive Fatigue ☐ Weight Loss ☐ Weight Gain

EYE ☐ **None** ☐ Double Vision ☐ Blurred Vision ☐ Blindness

RESP ☐ **None** ☐ Cough ☐ Coughing Blood ☐ Shortness Of Breath ☐ Bloody Sputum

GU ☐ **None** ☐ Difficulty Urinating ☐ Frequent Urination

GI ☐ **None** ☐ Diarrhea ☐ Blood In Stool ☐ Heartburn ☐ Bowel Problems ☐ Nausea/Vomiting

CV ☐ **None** ☐ Chest Pain/Angina ☐ Palpitations ☐ Fainting ☐ Bowel Problems

MUSCULOSKELETAL

☐ **None** ☐ Neck Pain ☐ Muscle Pain ☐ Joint Pain ☐ Joint Swelling ☐ Jaw Pain

SKIN ☐ **None** ☐ Skin Lesions/Moles ☐ Slow-Healing Wound(s)

NEURO/PSYCH

☐ **None** ☐ Headache ☐ Numbness Of Face ☐ Numbness Of Arms Or Legs ☐ Weakness Of Arms Or Legs
☐ Convulsions ☐ Visual Changes ☐ Memory Problems ☐ Coordination Problems ☐ Unusual Perceptions
☐ Hallucinations

ENDO ☐ **None** ☐ Heat Or ☐ Cold Intolerance ☐ Excessive Thirst ☐ Changes Of Hair Growth Or Pattern

ALLERGY/IMMUNOLOGY

☐ **None** ☐ Sneezing ☐ Red/Itchy Eyes ☐ Itching ☐ Hives

HEMATOLOGIC/LYMPHATIC

☐ **None** ☐ Bleeding Easily ☐ Bruising Easily ☐ Lymph Node Swelling

Other chronic symptoms that are of a concern to you:

Patient Signature Date

(Reviewed by MD)

Patient Label

rev 02052009p2

MEDICAL HISTORY