EVMS HEARING AND BALANCE CENTER GENERAL HEALTH HISTORY

Patient Name ________________________________ Date______________ Chart # _________________

Age ___________ Date of Birth __________________ Reason for visit ___________________________________

Race __________ Sex (circle): Male Female Marital Status (circle) Single Married Widowed

Primary Care Physician _______________________________ Referring Physician ________________________________

Other treating Physicians ____

Medications

List all medications that you are taking including vitamins and over the counter medicines

Name	Strength (for example 5mg)	How often?	Condition being treated

Do you have any allergies to medicines? ☐ No ☐ Yes

Please list ____

Do you have any allergies to mold, dander, or other environmental agent? Please list _______________________

Do you have any food allergies? Please list ____

Social History

Occupation____________________________________ Retired ☐ No ☐ Yes

Tobacco:
- None ______________
- Chew ______________
- Smoke_____________
- <1 pack/day _________
- >1 pack/day _________

Alcohol:
- None __________________
- Rare ___________________
- 1-3 drinks/wk ____________
- 1-3 drinks/day ___________
- >3 drinks/day ____________

Drugs:
- None ______________
- Marijuana __________
- Other _____________

Diet:
- Salty foods ______________
- Caffeine ________________

Are you or could you be pregnant? ☐ No ☐ Yes

MD Initials_____________________

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Medical History

Have you or any of your family members ever had any of the following? Check all that apply…

Condition	**I have had/do have**	**My family member has had/does have**	**Family Member**
Acid Reflux			
Allergy			
Anemia			
Angina or Heart Attack			
Arrythmia (abnormal heart beat)			
Arthritis			
Asthma			
Bleeding problems			
Cancer			
Chronic Bronchitis			
Diabetes			
Emphysema			
Head Injury			
Heart Failure			
Heart Murmur			
Hepatitis or Liver problems			
High Blood Pressure			
Intestinal Problems			
Kidney disease			
Leukemia/Lymphoma			
Migraine			
Psychiatric problems			
Reproductive problems			
Seizure disorder			
Stroke			
Thyroid disorder			
Tuberculosis			
Urinary Problems			
Vascular disease			

Surgical History

List all of your surgeries

Surgery	Date

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes

If yes, please list what sort of problems. ____

Hospitalizations

Please list any hospitalizations

Date	Reason

MD Initials___________________

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Review of Symptoms

Please circle yes or no to indicate if you have had any of the following symptoms or diseases.

Neurological/Musculoskeletal		
Stroke	Yes	No
Migraine	Yes	No
Fainting	Yes	No
Weakness	Yes	No
Numbness	Yes	No
Head injury	Yes	No
Headaches	Yes	No
Arthritis	Yes	No
Muscle or joint aches	Yes	No
Fatigue	Yes	No
Memory loss	Yes	No
Seizures	Yes	No

Cardiovascular		
Swollen ankles or lower legs	Yes	No
Skipped or abnormal heart beat	Yes	No
Chest pain	Yes	No
High blood pressure	Yes	No
Heart disease	Yes	No
Rheumatic fever	Yes	No
Heart murmur	Yes	No

Respiratory		
Pneumonia	Yes	No
Asthma	Yes	No
Chronic cough	Yes	No
Shortness of Breath	Yes	No

Head and Neck		
Vision problems or double vision	Yes	No
Dry eyes or itchy eyes	Yes	No
Glaucoma	Yes	No
Sneezing or runny nose	Yes	No
Change in smell	Yes	No
Sinus problems	Yes	No
Hoarseness	Yes	No
Neck mass	Yes	No
Enlarged lymph nodes	Yes	No
Dental, Mouth or Throat pain	Yes	No
Snoring or Sleep Apnea	Yes	No
Difficulty or painful swallowing	Yes	No
Ear infections or drainage	Yes	No
Ear fullness or earache	Yes	No
Noise in ears or head	Yes	No
Hearing loss	Yes	No
Exposure to loud sound	Yes	No
Dizziness	Yes	No
Facial Paralysis or numbness	Yes	No

Infections		
AIDS	Yes	No
HIV	Yes	No
Tuberculosis	Yes	No
Syphilis	Yes	No
Chicken pox	Yes	No
Mumps	Yes	No
Lymes disease	Yes	No

Emotional		
Depression	Yes	No
Excessive stress	Yes	No
Anxiety	Yes	No
Suicidal tendencies	Yes	No

Genital/Urinary		
Urinary burning	Yes	No
Kidney disease	Yes	No
Prostate problems	Yes	No
Pregnancy	Yes	No

Dermatologic		
Rashes	Yes	No
Psoriasis	Yes	No
Skin Cancers	Yes	No

Endocrine		
Thyroid problems	Yes	No
Diabetes	Yes	No

Gastrointestinal		
Constipation	Yes	No
Diarrhea	Yes	No
Ulcer	Yes	No
Heartburn	Yes	No
Liver disease or Hepatitis	Yes	No
Nausea	Yes	No

General		
Weight loss	Yes	No
Cancer	Yes	No
Fever or chills	Yes	No
Trouble sleeping	Yes	No
Excessive bleeding	Yes	No
Easy bruising	Yes	No

Other __________________

MD Initials____________________

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