NAME: (Last, First) _____ Date: ____/____/____

MAJOR COMPLAINTS: (Why are you here Today?)_____

HOW LONG ARE YOU EXPERIENCING THIS?_____

ARE YOU EXPERIENCING ANY OF THE SYMPTOMS BELOW? (Please Check)

- ☐ Difficulty Hearing
- ☐ Ringing in the Ears
- ☐ Dizziness
- ☐ Clicking in the Ears
- ☐ Itching in the Ears
- ☐ Earaches
- ☐ Nasal Problems
- ☐ Snoring
- ☐ Nose Bleeds
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Throat Pain
- ☐ Neck Pain
- ☐ Shortness of Breath

ARE YOU TAKING ANY MEDICATIONS? (Please List) _____

DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICATIONS?_____

DO YOU HAVE ANY KNOWN ALLERGIES?_____

DO YOU SMOKE? ☐ No ☐Yes How Much? _____ ALCOHOL USAGE: ☐ No ☐ Yes How Much?_____

DO YOU HAVE ANY MEDICAL PROBLEMS? (If Yes, Explain)_____

DO YOU OR ANY MEMBER OF YOUR FAMILY HAVE ANY OF THE FOLLOWING? (Please Check)

	Self	Family Member		Self	Family Member
High Blood Pressure	☐	☐	Eczema	☐	☐
Heart Disease	☐	☐	Chronic Headaches	☐	☐
Angina	☐	☐	Thyroid Problems	☐	☐
Arthritis	☐	☐	Ulcers	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐
Diabetes	☐	☐	Kidney Disease	☐	☐
Emphysema	☐	☐	Glaucoma	☐	☐
Pneumonia	☐	☐	Cancer	☐	☐
Bronchitis	☐	☐	Alcoholism	☐	☐
Tonsillitis	☐	☐	Drug Abuse	☐	☐
Strep Throat	☐	☐	HIV +	☐	☐
Chronic Ear Infections	☐	☐	Other:_____		

HAVE YOU EVER BEEN HOSPITALIZED? (If Yes, Explain) _____

DID YOU EVER HAVE ANY SURGERY? (Please give dates and Explain)_____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? ☐ YES ☐ NO If Yes, Please explain why?_____

NAME OF PHYSICIAN? _____
ADDRESS:_____