LOS ANGELES CENTER FOR
EAR, NOSE, THROAT AND ALLERGY

Patient Name:_____
DOB:_____ Today's Date:_____

MEDICAL HISTORY: Please check box for yes.

☐Acid Reflux
☐AIDS/HIV
☐Allergic Rhinitis
☐Anemia
☐Anxiety/Depression
☐Arthritis
☐Asthma
☐Bleeding Disorders
☐Cancer, type_____
☐Chron's Disease
☐Circulation problems
☐Dimentia/Alzheimers
☐Diabetes
☐Dizziness/Vertigo
☐Ear Infections
☐Eczema

☐Have you ever had any loud noise exposure? if yes, when and where? _____
☐Have you been in the military?
☐Are you or have you ever been exposed to chemicals?
☐Have you ever been involved in a mal practice law suit?

CURRENT SYMPTOMS: Please check box if you are currently experiencing any of the following symptoms.

☐Fever
☐Chills
☐Night Sweats
☐Weight Loss
☐Blurred Vision
☐Double Vision
☐Dryness of eyes
☐Eye Pain
☐Ear Pain
☐Sinus Pressure
☐Sneezing
☐Nasal Congestion
☐Nasal Drainage
☐Hearing Loss
☐Ringing In Ears
☐Vertigo/Dizziness
☐Sore Throat
☐Hoarseness/Voice change
☐Chest Pain

☐Enlarged Glands
☐Enlarged Thyroid
☐Epilepsy/Seizures
☐Fainting Spells
☐Lymph Node swelling
☐Hyperthyroidism
☐Problems with anesthesia
☐Rapid Heartbeat
☐Lightheadedness
☐Shortness of Breathe
☐Difficulty Breathing
☐Cough
☐Heartburn
☐Difficulty Swallowing
☐Abdominal/Stomach Pain
☐Vomiting
☐Blood in stools
☐Itching
☐Rash

☐New skin lesions
☐Numbness or Tingling
☐Lack of coordination
☐Frequent Headaches
☐Joint pain
☐Muscle Pain
☐Cold Intolerance
☐Kidney Disease
☐Migraine Headaches
☐Meningitis
☐Multiple Sclerosis
☐Neuritis/Neuralgia
☐Tuberculosis
☐Easy bleeding
☐Heat Intolerance
☐Excessive Thirst
☐Excessive Urination
☐Easy bruising
☐Emphysema/COPD

☐Frequent Colds
☐Frequent Sore throat
☐Glaucoma
☐Gonorrhea/Syphilis
☐ Hearing Loss
☐Heart Disease/Attack
☐Cold sores/Herpes
☐Hepatitis/Jaundice
☐High Cholesterol
☐Low/High blood pressure
☐Hives/Rashes
☐Difficulty sleeping
☐Nervous Breakdown
☐Paralysis
☐Pneumonia
☐Prostate enlargement
☐Sinus Infections
☐Sleep apnea/Snoring
☐Stomach Ulcers
☐Stroke

ADDITIONAL MEDICAL HISTORY: Please list any medical conditions not listed above:
_____
_____
_____

SURGERY: Please list all operations:
_____
_____
_____

MEDICATIONS: Include any over-the-counter medications and dosages:
_____
_____
_____

ALLERGIES: Include and medications, foods, radiographic IV contrast dye, iodine, etc.:
_____
_____
_____

HABITS

Alcoholic Beverages:

☐Never ☐Occasionally ☐Weekly ☐Daily ☐Quit

Tobacco:

☐Cigarettes ☐Cigars ☐Pipe ☐Snuff ☐Chewing Tobacco
☐Never ☐Occasionally ☐Weekly ☐Daily ☐Quit

Recreational Drug Use:

☐Marijuana ☐Cocaine ☐Heroin ☐Quit ☐Other_____

Family History: Has any blood Relative had any of the following diseases? If yes, who?

☐ Bleeding Problems _____
☐ Cancer _____
☐ Diabetes _____
☐ Heart Disease/Attack _____
☐ High Blood Pressure _____
☐ Stroke _____
☐ Dizziness _____
☐ Hearing Loss _____