



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
- Dementia/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.

- | | | |
|--|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> New skin lesions |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Enlarged Thyroid | <input type="checkbox"/> Numbness or Tingling |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Lack of coordination |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Lymph Node swelling | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Dryness of eyes | <input type="checkbox"/> Problems with anesthesia | <input type="checkbox"/> Cold Intolerance |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Rapid Heartbeat | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Sinus Pressure | <input type="checkbox"/> Shortness of Breathe | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Cough | <input type="checkbox"/> Neuritis/Neuralgia |
| <input type="checkbox"/> Nasal Drainage | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Easy bleeding |
| <input type="checkbox"/> Ringing In Ears | <input type="checkbox"/> Abdominal/Stomach Pain | <input type="checkbox"/> Heat Intolerance |
| <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Excessive Urination |
| <input type="checkbox"/> Hoarseness/Voice change | <input type="checkbox"/> Itching | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Rash | <input type="checkbox"/> Emphysema/COPD |



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- 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

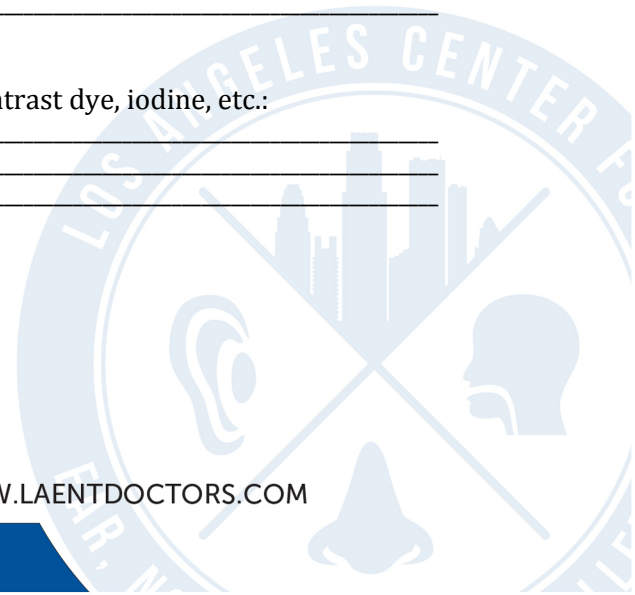
ADDITIONAL MEDICAL HISTORY: Please list any medical conditions not listed above:

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





LOS ANGELES CENTER FOR EAR, NOSE, THROAT AND ALLERGY

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 _____





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