ARRIGG EYE & EAR ASSOCIATES MEDICAL HISTORY FORM

NAME: ______________________ Date of Birth: ___________ DATE: ___/_______/___

PRIMARY CARE OR REFERRING PHYSICIAN: ____.

LOCATION OF PROBLEM: EAR LEFT RIGHT BOTH SINUS TONSILS NECK HEAD

DURATION OF PROBLEM: ______________________________.

SEVERITY OF PROBLEM: MILD MODERATE SEVERE CONSTANT COMES AND GOES

DESCRIBE THE PROBLEM: ____
____
____

REVIEW OF SYSTEMS (PLEASE CHECK YES OR NO)

YES	NO		YES	NO	
☐	☐	Ringing in the ears	☐	☐	Environmental allergies
☐	☐	Double or blurred vision	☐	☐	Sinus problems
☐	☐	Dizziness	☐	☐	Sore throats
☐	☐	Noise exposure source)__________	☐	☐	Cough
☐	☐	History of ear infections	☐	☐	Chest Pain
☐	☐	Fatigue	☐	☐	Weight loss or gain
☐	☐	Swollen Glands	☐	☐	Heartburn
☐	☐	Muscle Aches	☐	☐	Rashes

YOUR MEDICAL HISTORY (PLEASE CHECK YES OR NO)

YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Hepatitis
☐	☐	Asthma	☐	☐	High blood pressure
☐	☐	Bleeding problems	☐	☐	High Cholesterol
☐	☐	Cancer	☐	☐	HIV/AIDS
☐	☐	Diabetes	☐	☐	Migraines
☐	☐	Stress or Depression	☐	☐	Thyroid problems
☐	☐	Heart problems	☐	☐	Ear surgery

ALLERGIES (PLEASE CIRCLE ONE)

ALLERGY TO IVP DYE: YES NO **ALLERGY TO SHELLFISH:** YES NO

DO YOU HAVE ANY METAL PARTS IN YOUR BODY YES OR NO **WHERE?**____________

OTHER ALLERGIES: ____.

FAMILY MEDICAL HISTORY(PLEASE CHECK YES OR NO)

YES	NO		YES	NO	
☐	☐	High blood pressure	☐	☐	Smoke? how much____
☐	☐	Hearing loss who?_____________			
☐	☐	Diabetes	☐	☐	Alcohol? mild mod heavy

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:
(IF YOU BROUGHT A LIST WITH YOU, PLEASE GIVE IT TO THE FRONT DESK).

- ❖ ____________________________ ❖ ____________________________
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