Oregon Health & Science University
Hospitals and Clinics
Department of Otolaryngology/
Head & Neck Surgery

NEW PATIENT HISTORY OTOLOGY

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

CLINICIAN NOTES ONLY

Patient Age:____________

Please answer all of the following questions to the best of your ability.

Please write N/A if the question is NOT applicable to you.

CHIEF COMPLAINT:
What is the reason for this appointment?____

HISTORY OF PRESENT ILLNESS:
Which of the following symptoms do you suffer?

- ☐ Hearing loss
- ☐ Dizziness
- ☐ Drainage from ear
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Headache
- ☐ Sinus symptoms

When did the problem(s) start?____

Does anything make it better or worse?____

Any other associated symptoms?____

Have you been tested for allergies? ☐ Yes ☐ No When:_______ Results:_______________

PAST MEDICAL HISTORY:

List the medicines you are taking:
1.__________________________
2.__________________________
3.__________________________
4.__________________________
5.__________________________
6.__________________________

List medical conditions you are/have been treated for (high blood pressure, diabetes, etc.)________________
____

List previous ear surgeries:____________________

List (other) previous surgeries:________________

List drug allergies:____________________________

If you have had a CT or MRI, where was it performed?________________________

Do YOU have any of the following:

NO	YES		NO	YES	
☐	☐	Asthma/Lung disease	☐	☐	Heartburn/Reflux
☐	☐	Arthritis	☐	☐	Kidney disease
☐	☐	Diabetes	☐	☐	Migraines
☐	☐	Excessive bleeding	☐	☐	Seizures
☐	☐	Fevers	☐	☐	Depression
☐	☐	Heart Disease	☐	☐	Stroke

If YES please describe:________________________
____

SOCIAL HISTORY:
Your occupation:
____

Do you smoke/chew tobacco?
☐ Yes ☐ No How much:_________

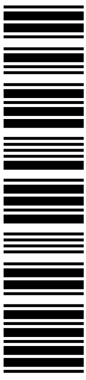
Do you drink alcohol?
☐ Yes ☐ No How much:_________

FAMILY HISTORY:
Diseases that run in your family:
____
____

REFERRAL:
Who referred you to the office today?______________

Their address:______________________________

CLINICIAN USE ONLY: DR________________________ HAS REVIEWED THE ABOVE INFORMATION WITH THE PATIENT DATE:_______________



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