EAR & HEARING
Otology I Neurotology I Audiology

Date: ______________________

Patient Name: ____

DOB: ______________________

Account Number:

ABRAHAM JACOB, MD
ADULT OTOLOGY
NEW PATIENT CONSULT

REASON FOR VISIT: ____

REFERRING PHYSICIAN: ________________________ PRIMARY CARE PHYSICIAN: ________________________

CURRENT MEDICAL HISTORY

1.) CHECK ALL THAT APPLY. IF "YES" PLEASE EXPLAIN:

	YES	NO			YES	NO	
DIABETES	❑	❑	____________	KIDNEY PROBLEMS	❑	❑	____________
HIGH BLOOD PRESSURE	❑	❑	____________	NEUROLOGICAL PROBLEM	❑	❑	____________
HEART DISEASE	❑	❑	____________	CANCER	❑	❑	____________
BLEEDING DISORDER	❑	❑	____________	DEPRESSION/ANXIETY	❑	❑	____________
LUNG (ASTHMA, BRONCHITIS)	❑	❑	____________	ALLERGY PROBLEMS	❑	❑	____________
LIVER PROBLEMS	❑	❑	____________	ANESTHESIA PROBLEMS	❑	❑	____________

OTHER MEDICAL PROBLEMS: ____

____

2.) LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

3.) ALLERGIES TO MEDICATIONS:

ALLERGY	REACTION	ALLERGY	REACTION

4.) LIST ANY RECENT SURGERIES & HOSPITALIZATIONS:

SURGERIES	YEAR	HOSPITALIZATIONS	YEAR

SOCIAL HISTORY

1.) DO YOU SMOKE TOBACCO?
- ☐ **YES**, CURRENT DAY SMOKER. I HAVE SMOKED FOR _______________ YEARS.
- ☐ **NO**, FORMER SMOKER. YEAR I QUIT SMOKING: ____________.
- ☐ **NO**, I'VE NEVER SMOKED.

2.) DO YOU DRINK ALCOHOL?
- ☐ **YES**, DAILY.
- ☐ **YES**, 1 OR MORE TIMES PER WEEK.
- ☐ **YES**, 1 OR MORE TIMES PER MONTH.
- ☐ **NO**

3.) DO YOU USE RECREATIONAL OR ILLEGAL DRUGS?
- ☐ **YES**, TYPE & FREQUENCY: ____
- ☐ **NO**

4.) HAVE YOU RECEIVED THE FOLLOWING VACCINES:

A.) FLU VACCINE:
- ☐ **YES**, MONTH/YEAR________
- ☐ **NO,** DECLINED VACCINE
- ☐ **NO,** ALLERGY TO VACCINE

B.) PNEUMONIA VACCINE:
- ☐ **YES,** ☐**PREVNAR 13**, MONTH/ YEAR______________. ☐**PNEUMOVAX 23**, MONTH/ YEAR_________________.
- ☐ **NO**

5.) FALLS: HAVE YOU FALLEN 2 OR MORE TIMES IN THE PAST YEAR?
- ☐ **YES**, IF YES WHAT WAS THE CAUSE____
- ☐ **NO**

6.) DO YOU HAVE A LIVING WILL?
- ☐ **YES**
- ☐ **NO**

7.) DO YOU LIVE ALONE?
- ☐ **YES**
- ☐ **NO**

8.) ARE YOU PRESENTLY:
- ☐ **WORKING**
- ☐ **RETIRED**
- ☐ **DISABLED**

OCCUPATION (OR PREVIOUS OCCUPATION):_______________________________________

9.) MARITAL STATUS:
- ☐ **SINGLE**
- ☐ **MARRIED**
- ☐ **DIVORCED**
- ☐ **SEPARATED**
- ☐ **WIDOWED**

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FAMILY HISTORY:

10.) LIST ANY MEDICAL PROBLEMS WITHIN THE FAMILY:

	YES	NO	
HEARING LOSS	☐	☐	______
BLEEDING DISORDER	☐	☐	______
CANCER	☐	☐	______
HEART DISEASE	☐	☐	______
DIABETES	☐	☐	______

OTHER MEDICAL PROBLEMS WITHIN THE FAMILY: ______

REVIEW OF SYSTEMS:

		YES	NO		YES	NO
GENERAL	FEVER	☐	☐	WEIGHT LOSS ☐ OR GAIN ☐	☐	☐
EYES	WEAR GLASSES	☐	☐	INJURIES/TRAUMA TO EYES	☐	☐
CARDIOVASCULAR	CHEST PAIN	☐	☐	IRREGULAR PULSE	☐	☐
RESPIRATORY	CHRONIC COUGH	☐	☐	SHORTNESS OF BREATH	☐	☐
NEUROLOGICAL	FAINTING	☐	☐	CHRONIC HEADACHE	☐	☐
PSYCHIATRIC	DEPRESSION	☐	☐	ANXIETY	☐	☐
	SCHIZOPHRENIA	☐	☐	MANIC DEPRESSION	☐	☐
SKIN	RASH	☐	☐	ITCHING	☐	☐
	HIVES	☐	☐	SKIN LESION(S)	☐	☐
MUSCULOSKELETAL	JOINT PAIN	☐	☐	MUSCLE PAIN	☐	☐
GI	NAUSEA	☐	☐	VOMITING	☐	☐
ENDOCRINE	EXCESSIVE THIRST	☐	☐	FEEL WARMER THAN OTHERS	☐	☐
				FEEL COOLER THAN OTHERS	☐	☐
HEMATOLOGY/LYMPH	SWOLLEN GLANDS	☐	☐	BLEEDING PROBLEM	☐	☐
ALLERGY	FOOD ALLERGIES	☐	☐	INHALANT ALLERGIES	☐	☐

		YES	NO		YES	NO
ENT	EAR PAIN	☐	☐	EAR DRAINAGE	☐	☐
	EAR PRESSURE	☐	☐	TINNITUS/EAR NOISES	☐	☐
	HEARING LOSS	☐	☐	VERTIGO (SPINNING)	☐	☐
	IMBALANCE	☐	☐	NASAL CONGESTION	☐	☐
	HOARSENESS	☐	☐	SORE THROAT	☐	☐
	WEAR HEARING AID	☐	☐	FACIAL NUMBNESS	☐	☐

OTHER: ____

FOR OFFICE USE ONLY

REVIEWED BY: ______________________________ DATE: ______________________________

ABRAHAM JACOB, MD
OTOLOGY, NEUROTOLOGY & CRANIAL BASE SURGERY