EAR & HEARING
Otology I Neurotology I Audiology

Date:

Patient Name:

DOB:

ABRAHAM JACOB, MD
ESTABLISHED PATIENT VISIT

REASON FOR VISIT:____

REFERRING PHYSICIAN: ___________________________ **PRIMARY CARE PHYSICIAN:** ___________________________

CURRENT MEDICAL HISTORY

1.) MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

2.) ALLERGIES TO MEDICATIONS:

3.) NEW MEDICAL PROBLEMS / DIAGNOSIS:

4.) RECENT SURGERIES / ER VISITS:

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**

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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**

REVIEW OF SYSTEMS

PLEASE CHECK ALL THAT APPLY:

		YES	NO		YES	NO
GENERAL	FEVER	☐	☐	WEIGHT LOSS ☐ OR GAIN ☐	☐	☐
CARDIOVASCULAR	CHEST PAIN	☐	☐	IRREGULAR PULSE	☐	☐
ENT	EAR PAIN	☐	☐	EAR DRAINAGE	☐	☐
	EAR PRESSURE	☐	☐	TINNITUS/EAR NOISES	☐	☐
	HEARING LOSS	☐	☐	VERTIGO (SPINNING)	☐	☐
	IMBALANCE	☐	☐	NASAL CONGESTION	☐	☐
	HOARSENESS	☐	☐	SORE THROAT	☐	☐
	WEAR HEARING AID	☐	☐			

FOR OFFICE USE ONLY

REVIEWED BY: ______________________ DATE: ______________________

ABRAHAM JACOB, MD
OTOLOGY, NEUROTOLOGY & CRANIAL BASE SURGERY