TAMPA BAY HEARING & BALANCE Center

NEW PATIENT PACKET

Patient's Last Name ***First Name*** ***M.I.*** ***DOB:*** ***Date:***

_____ _____ _____

A. Reason for Visit: _____

B. Referring Physician and Primary Care Physician: (*Fill out if you have been referred by your physician for this visit.*)

Primary Physician's Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Referring Physician's Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

C. Pharmacy:

Pharmacy Name: _____

Address (Street, City): _____

Phone Number: _____

D. Medications:

List all the medications that you are taking. If you are attaching your own list, please check here □

Name Strength and Frequency

_____

_____

_____

_____

_____

_____

E. Allergies:

Do you have allergies to medications? □ No □ Yes □ Don't Know

If yes, please list below:

_____

F. Medical and Surgical History:

List all significant **medical conditions, surgeries, and hospitalizations**. Please include the relevant dates as well.

Medical Conditions / Surgeries / Hospitalizations Date

_____ ____

_____ ____

_____ ____

_____ ____

_____ ____

_____ ____

G. Vitals: What is your height? _____ feet _____ inches.

H. Family History:

Please check the box if any of the following diseases are common in your family or have occurred in any family member.

□ Allergies	□ Cancer	□ Migraines
□ Asthma	□ Heart Disease	□ Bleeding Disorder
□ Autoimmune Disease	□ Stroke	□ Other _____
□ Diabetes	□ Hearing Loss	

I. Social History:

1. Do you currently smoke cigarettes? □ No □ Yes _____ Packs per Day _____ Number of Years

2. Have you ever smoked in the past? □ No □ Yes _____ Packs per Day _____ Number of Years

3. Do you drink alcohol? □ No □ Yes _____ Glasses per Day / Week / Month

4. Do you drink caffeinated products? □ No □ Yes _____ Cups per Day

5. What is your present occupation? _____

J. Review of Systems:

General:

Fatigue □ No □ Yes

Fever □ No □ Yes

Eyes:

Blurred Vision □ No □ Yes

Double Vision □ No □ Yes

Ears, Nose, and Throat:

Dizziness □ No □ Yes

Ear Drainage □ No □ Yes

Hearing Loss □ No □ Yes

Sinusitis □ No □ Yes

Allergies □ No □ Yes

Nasal Congestion□ No □ Yes

Runny Nose □ No □ Yes

Respiratory:

Short of Breath □ No □ Yes

Wheezing □ No □ Yes

Cardiovascular:

Chest Pain □ No □ Yes

Palpitations □ No □ Yes

Gastrointestinal:

Abdominal Pain □ No □ Yes

Heartburn □ No □ Yes

Genitourinary:

Blood in Urine □ No □ Yes

Painful Urination □ No □ Yes

Endocrine:

Cold Intolerance □ No □ Yes

Heat Intolerance □ No □ Yes

Neurological:

Fainting □ No □ Yes

Tremor □ No □ Yes

Weakness □ No □ Yes

Psychiatric:

Anxiety □ No □ Yes

Depression □ No □ Yes

Suicidal Thoughts□ No □ Yes

Blood/Lymphatic:

Easy Bleeding □ No □ Yes

Easy Bruising □ No □ Yes

Cancer □ No □ Yes

Infections:

HIV Positive □ No □ Yes

Syphilis □ No □ Yes

Tuberculosis □ No □ Yes

Hepatitis □ No □ Yes

K. General Questions

Yes No

□ □ 1. Have you ever had ear surgery? If yes, _____

□ □ 2. Do you currently wear hearing aids?

□ □ 3. Have you ever worn hearing aids in the past?

□ □ 4. Do you have blood relatives with hearing loss? If yes, then whom? _____

□ □ 5. Have you ever taken medications known to be damaging to your ears? If yes, circle the medication:

Gentamicin / Other Mycin Antibiotics / Vicodin / Viagra, Cialis / High Dose Aspirin / Others _____

□ □ 6. Have you ever suffered a severe head injury?

□ □ 7. Have you, in your job or hobbies, been exposed to loud noise levels?

□ □ 8. Have you experienced a fall in the past 12 months?