Dr. Georgakakis
Otolaryngology • Ear Nose & Throat
Hearing Health

PAST MEDICAL HISTORY

Patient Name: _____ Reason For Visit _____

HEAD-SINUSES:	Yes	No
FACIAL PAIN	☐	☐
HEADACHES	☐	☐
CONGESTION	☐	☐
HEAD/FACIAL TRAUMA	☐	☐
SINUS SURGERY	☐	☐

RESPIRATORY:	Yes	No
SHORTNESS OF BREATH	☐	☐
COUGH	☐	☐
ASTHMA	☐	☐
PNEUMONIA	☐	☐
BRONCHITIS	☐	☐

SKIN:	Yes	No
RASH	☐	☐
LESIONS	☐	☐
HIVES	☐	☐
HISTORY OF SKIN CANCER	☐	☐

ENDOCRINE:	Yes	No
DIABETES	☐	☐
OBESITY	☐	☐
HAIR LOSS	☐	☐
THYROID DISEASE	☐	☐

PSYCHIATRIC:	Yes	No
ANXIETY	☐	☐
SLEEP DISORDER	☐	☐
SNORING OR APNEA	☐	☐
MEMORY LOSS	☐	☐
DRUG ADDICTION	☐	☐
DEPRESSION	☐	☐

EARS-HEARING:	Yes	No
HEARING LOSS	☐	☐
RINGING IN THE EARS	☐	☐
LOSS OF BALANCE	☐	☐

NOSE:	Yes	No
BLEEDING	☐	☐
RUNNY NOSE	☐	☐
LOSS OF SMELL	☐	☐
PRESSURE	☐	☐
POSTNASAL DRAINAGE	☐	☐

THROAT:	Yes	No
SORE	☐	☐
HOARSENESS	☐	☐
LOSS OF TASTE	☐	☐
SNORING	☐	☐
TONSILLITIS	☐	☐

GI:	Yes	No
DIFFICULTY SWALLOWING	☐	☐
HEARTBURN	☐	☐
REFLUX	☐	☐
NAUSEA	☐	☐
VOMITING	☐	☐
HIATAL HERNIA	☐	☐

GU:	Yes	No
PROSTATE	☐	☐
KIDNEY STONE	☐	☐
DIALYSIS	☐	☐
GOUT	☐	☐

EYES:	Yes	No
DOUBLE VISION	☐	☐
ITCHING	☐	☐
VISION LOSS	☐	☐
PAIN	☐	☐
BURNING	☐	☐
DRY EYES	☐	☐
GLAUCOMA	☐	☐

CONSTITUTIONAL SYMPTOMS:	Yes	No
FATIGUE	☐	☐
FEVER	☐	☐
CHILLS	☐	☐
NIGHT SWEATS	☐	☐
WEIGHT LOSS OR GAIN	☐	☐

NEUROLOGICAL:	Yes	No
PASSING OUT	☐	☐
DIZZINESS	☐	☐
NUMBNESS	☐	☐
STROKE	☐	☐
SEIZURES	☐	☐
TREMORS	☐	☐

CARDIOVASCULAR:	Yes	No
HYPERTENSION	☐	☐
HIGH CHOLESTEROL	☐	☐
PAST HEART ATTACKS	☐	☐
PACEMAKER	☐	☐

HEMATOLOGIC-LYMPHATIC:	Yes	No
HIV/AIDS	☐	☐
ANEMIA	☐	☐
IMMUNE PROBLEMS	☐	☐
PULMONARY EMBOLISM	☐	☐

MUSCULOSKELETAL:	Yes	No
JOINT PAIN	☐	☐
ARTHRITIS	☐	☐
JAW PAIN	☐	☐
HIP / KNEE REPLACEMENT	☐	☐
OSTEOPOROSIS	☐	☐
LUPUS	☐	☐

Any other medical conditions: _____

Past surgical history: ☐ Yes ☐ No If yes, please list the procedures and dates: _____

Family history of medical problems: ☐ Yes ☐ No If yes, please list and indicate family member: _____

List all allergies: ☐ No Allergies: _____

List all medications you are currently taking (including all over the counter medications and vitamins): ☐ None

_____

Are you currently using tobacco products? ☐ Yes ☐ No If yes, quantity smoked per day: _____

If you quit, how often did you smoke before (per day)? _____ For how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, amount: _____ How often: _____

Do you currently have or have you in the past had a problem with substance abuse? ☐ Yes ☐ No

Patient / Representative Signature: _____ Date: _____