EAR, NOSE & THROAT SPECIALISTS
of Northern Virginia, P.C.

PROFESSIONAL HEARING SERVICES
The Dizziness and Balance Center
The Hearing Aid Center

REVIEW OF SYMPTOMS

Patient Name: ________________________________ DOB: ______ / ______ / ______ Age: ____________________________

Reason for Visit: ____

To help us meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

VITALS: Height: _______ Ft _______ In Weight: _______ Lbs. (Office Use Only) Bp: _______ Pulse: _______

1. Past Medical History – Have you ever had the following: ☐ No Significant Past Medical History

☐ Allergic Rhinitis	☐ Diabetes	☐ Hypertension	☐ Sinusitis
☐ Arthritis	☐ Eczema	☐ Meniere's Disease	☐ Snoring
☐ Asthma	☐ Elevated Cholesterol	☐ Middle Ear Inf	☐ Stroke
☐ Autoimmune Disorder	☐ Epistaxis	☐ Migraines	☐ TMD
☐ Cancer (type) _________________	☐ HIV	☐ Nasal Injury	☐ Thyroid Disorder
☐ Cerumen (wax)	☐ Hearing Loss	☐ Nasal Polyps	☐ Tonsillitis
☐ Cholesteatoma	☐ Head Injury	☐ Pharyngitis	☐ Other ____________________
☐ Deviated Nasal Septum	☐ Heart Attack	☐ Sleep Apnea	

2. Past Surgical History – Have you ever had the following: ☐ No Significant Past Medical History

☐ Sinus Surgery ☐ Tonsil/Adenoid ☐ Ear Surgery ☐ Ear Tubes ☐ Thyroid/Neck Surgery
☐ Vocal/Larynx Surgery ☐ Cervical Spine Surgery ☐ Other ____

3. **Current Medications:** *(Including over the counter) strength and dosage* ☐ No Medications

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4. Please List All Allergies: *(food, drugs, environment)* ☐ No Allergies

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5. Family History: *(food, drugs, environment)* ☐ No Family History of Problems

Relationship	Relationship
☐ Cancer ______________________________	What type of cancer? ______________________________
☐ Neurology Disorder ______________________________	☐ Diabetes ______________________________
☐ Hearing Loss ______________________________	☐ Stroke ______________________________
☐ Heart Disease ______________________________	☐ Kidney Problems ______________________________
☐ Hypertension ______________________________	☐ Bleeding Problems ______________________________

8314-C Traford Lane, Springfield, VA 22152 • 8644 Sudley Road, Suite 114, Manassas, VA 20110
1005 N. Glebe Road, Suite 500, Arlington, VA 22201 • 703.644.7800 • www.entnova.com

6. Social History:

Occupation ____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Tobacco:☐ Never ☐ Former smoker (quit ____ years ago) ☐ Active everyday (____ packs/day x ____ years) ☐ Minimal

Alcohol: ☐ Never ☐ Social ☐ less than 10 per week ☐ more than 10 per week

7. Review of Systems: *Please mark the symptoms you currently have or had within the past 6 months.*

Constitutional

☐ Fever ☐ Fatigue ☐ Poor Appetite

Eyes

☐ Vision Change ☐ Dry Eyes ☐ Excessive Tearing

Head

☐ Headache ☐ Vertigo ☐ Dizziness
☐ Dental Problems ☐ Ear Pain ☐ Hearing Loss
☐ Ringing In Ears ☐ Pulse In Ear ☐ Ear Discharge
☐ Pressure In Ear ☐ Itching In Ear ☐ Nasal Congestion
☐ Nose Bleeding ☐ Sinus Pain ☐ Postnasal Drip
☐ Decreased Smell ☐ Runny Nose ☐ Nasal Obst
☐ Sore Throat ☐ Mouth Ulcers ☐ Enlarged Tonsils
☐ Hoarseness ☐ Lump In Throat ☐ White Spots In Mouth

Cardiovascular

☐ Chest Pain ☐ Syncope ☐ Irregular Heartbeats

Respiratory

☐ Wheezing ☐ Snoring ☐ Shortness Of Breath

Gastrointestinal

☐ Nausea ☐ Heartburn ☐ Difficulty Swallowing
☐ Excessive Belching

Integument

☐ Rash ☐ Dry Skin ☐ Itching

Neurological

☐ Seizure ☐ Tremors ☐ Tingling Or Numbness
☐ Muscular Weakness ☐ Memory Loss

Musculoskeletal

☐ Back Pain ☐ Joint Pain ☐ Neck Pain
☐ Swelling

Endocrine

☐ Weight Gain ☐ Weight Loss ☐ Cold Intolerance
☐ Hot Intolerance

Psychiatric

☐ Anxiety ☐ Depression

Blood-Lymph

☐ Easy Bleeding ☐ Easy Bruising ☐ Swollen Glands

Allergic-Immunologic

☐ Food Allergies ☐ Frequent Illness ☐ Environmental Allergies

____

Patient or Responsible Party (printed)

____ ____________________

Signature of Patient or Responsible Party Date