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Patient History Form

Date of Visit:

Patient Name:

Date of birth: ____/____/____

Reason for visit:

FOR ALL PATIENTS:

When did the problem start?

Overall, is the problem
getting worse better staying the
same?

Is the problem constant or intermittent?

If intermittent,
how often does each episode happen

and how long does each last

What makes the problem worse?

What makes it better?

Other doctors you have visited.

What was the assessment?

Please bring with you to your
appointment:

1. This form completed.
2. A copy of your previous medical records.
3. Any MRI or CT scans you may have had (not just reports).
4. The names and numbers of people to whom we should forward our report.

(Please leave the right column of this form blank)

What have you done so far for treatment?

Has it worked? Yes No

IF you have hearing loss or ear discomfort,
please answer the following:

RIGHT ear: stable loss
 slowly worsening
 suddenly worse
 fluctuating

LEFT ear: stable loss
 slowly worsening
 suddenly worse
 fluctuating

Do you use hearing aids or have you tried
them? Yes No

Can you use the telephone with both
ears? Yes No

If no, which ear do you use?

Do you have difficulty "popping" your
ears? Yes No

Do you ever have drainage from either ear?
Yes No

Have you had surgery on either
ear? Yes No

IF you have ringing (tinnitus) in your ears,
please answer the following:

Which ear is affected? Right
Left Both

Is the sound (circle one) intermittent or constant?

Is the sound pulsatile? Yes No

Yes No Does it affect your ability to sleep?

Yes No Does it affect your ability to do
your normal
 daily activities?

IF you have imbalance or dizziness,
please answer the following:

Is the sensation most like:

Yes No Lightheadedness
(as when standing up
quickly)

Yes No Spinning sensation

Yes No Pulling sensation (choose one)
to Right to Left Varies

Yes No Nausea without sense of
movement

How long does the sensation of imbalance last?
(not associated nausea or malaise)

1-5 sec 10-60 sec 20 min-2
hrs
More than 4 hrs More than 24 hrs

Have you ever fallen due to your imbalance?

Yes No

Does the imbalance occur along with any of the
following?

Yes No Hearing loss

Yes No Ringing in ears

Yes No Fullness in ears

What makes your imbalance worse?

Yes No Change in the weather

Yes No Allergy attack

Yes No Certain times of the day, month,
or year

Yes No Lying down

Yes No Rolling over in bed

Yes No Looking up

Yes No Bending neck forward or back

Yes No Raising arms above head

Yes No Turning head quickly

Yes No Getting up quickly

Yes No Loud sounds

Yes No Nose-blowing

Yes No Straining

Yes No Busy visual scenes

Yes No Ceiling fans

Yes No Supermarket aisles

Yes No IMAX films

Yes No Video games

Yes No Breathing fast

Yes No Stress

- Yes No Anxiety
- Yes No Starting or stopping a medicine
- Yes No Menstrual period
- Yes No Eating a lot of salt
- Yes No Eating cheese, chocolate, red wine, or other food

IF you get headaches, please answer the following:

Where do the headaches hurt?

At what age did they start?

Yes No Have you taken medications for them?

Yes No Do you have changes in your vision, such as black spots, jagged lines, or loss of vision in one eye during a headache?

Yes No Do you have any other neurologic symptoms, such as weakness or difficulty speaking during your headaches?

Yes No Do they last four hours or more?

Yes No Any relationship to your menstrual period?

Yes No Any relationship to change in the weather?

Yes No Any relationship to allergy symptoms?

Yes No Is the headache worse if you skip caffeine?

Yes No Are the headaches relieved by quiet and sleep?

Yes No Motion sickness as a child?

Any relatives with migraine headaches?

ALL PATIENTS please answer the following:

Have you had:

Yes No Loud noise exposure (such as in the military,

in a factory, or as a recreational shooter)

Yes No Head trauma causing loss of consciousness,

fracture, or seizures

Yes No Exposure to chemotherapeutic medicines or

tuberculosis treatment

Yes No Exposure to intravenous antibiotics or were a

patient in an intensive care

unit

Yes No Syphilis or parent with syphilis

Yes No Radiation to the head or neck

Yes No Cleft palate

Yes No Previous ear surgery

Yes No Frequent ear infections as a child

Yes No Tick bite or spreading

rash

Yes No Premature birth

Yes No Tooth grinding or jaw joint pain

Past and current MEDICAL PROBLEMS, including glasses and change of prescription.

Include dates if possible.

Yes No Was there a change in any medical condition recently, or near the time your symptoms started?

Past SURGERIES. List dates if possible. Include ALL surgeries, including eye and gynecologic procedures. If known, note the reason for the procedure, the surgeon, and the hospital.

MEDICATION

Circle any of the following medicines you take:

- Aspirin Coumadin Lovenox
- Ibuprofen Insulin
- Glucophage Hormones (including birth control)
- Prednisone Immunosuppressive medicines
- Chemotherapy

Medicines you are currently taking (if not listed above).

Include name, amount, how often and why:

Yes No Did you change the dose or type of medication recently, or near the time your symptoms started?

ALLERGY

Please list any allergies to medicines or environmental allergens, and your reaction to each.

FAMILY HISTORY

Has anyone in your family ever had problems with:

(circle if appropriate)

- Anesthesia Bleeding Migraine
- Genetic syndrome Early hearing loss
- Neurologic disease Meniere's disease

List any significant medical problems of blood relatives.

General Health (Constitutional):

N/A

Recent weight change Tiredness

Eyes:

N/A

Vision Changes Burning
Loss of Vision Discharge/Tearing
Double vision Pain

Ears, Nose, Mouth, Throat:

(problems other than reason for today's visit)

N/A

Ringing in ears Itchy ears
Nasal discharge Sneezing
Growth in nose Pronunciation
difficulty
Difficulty swallowing Bleeding from
throat
Facial pain "Stuffy" nose
Nasal bleeding Chewing difficulty
Pain on swallowing Voice changes
Facial weakness Headache
Snoring Drooling
Lump in neck Heartburn
Sore throat Nasal obstruction
Nosebleed Loss of sense of smell
Mouth growth, ulcer Breathing difficulty
Dental problems/Poorly fitting dentures

Heart, Veins, Arteries (Cardiovascular):

N/A

Chest pain Leg pain with
walking
Irregular heart beat Leg pain with rest
Dizziness Swelling of
legs

Lungs (Respiratory):

N/A

Wheezing Cough
Coughing up blood Shortness of
breath

Stomach, Intestines (Gastrointestinal):

N/A

Decrease in appetite	Indigestion
Nausea/vomiting	Food intolerance
Blood in stool	Diarrhea/Constipation

Bones, Joints, Muscles (Musculoskeletal):

N/A	
Joint pain/Stiffness	Neck pain

Skin (Integumentary):

N/A	
Rash	Jaundice
Recent baldness	

Brain, Nerves (Neurological):

N/A	
Headache	Tingling/Numbness
Blackout	Tremor
Seizures	Paralysis

Psychiatric:

N/A	
Insomnia	Depression

Hormones (Endocrine):

N/A	
Excessive thirst, hunger, urination	
Thyroid trouble	Heat or cold intolerance
Excessive sweating	

Kidney, Bladder, Genitals (Genitourinary):

N/A	
Painful urination	Frequent urination
Difficulty passing urine	Blood in urine
Incontinence	

Blood (Hematologic/Lymphatic):

N/A	
Tendency to form blood clots	Bleeding problems