

AUSTIN EAR CLINIC
New Patient Information
If hand writing, PLEASE PRINT

Please check any of the following that apply to you.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Sudden Hearing Loss | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Ear Pain |
| <input type="checkbox"/> Gradual Hearing Loss | <input type="checkbox"/> Stopped-up Ears | <input type="checkbox"/> Draining Ears | <input type="checkbox"/> Trouble Understanding |
| <input type="checkbox"/> Allergy Symptoms | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Nose or Sinus Problems | <input type="checkbox"/> Throat Problems |
| <input type="checkbox"/> Noise in Your Head | <input type="checkbox"/> Ringing in Your Ears | <input type="checkbox"/> Pulsating Noise in Head | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Vertigo (spinning feeling) | <input type="checkbox"/> Noise Exposure | <input type="checkbox"/> Trouble Breathing through nose | <input type="checkbox"/> Cochlear Implant(s) |

Briefly state the reason for your initial visit with us.

Any ear/nose/throat/neck surgeries? Yes No **Have you had complications from anesthesia?** Yes No

Antibiotics: In the last 3 months, have you been on any treatment of antibiotics? Yes No

If YES, please list antibiotics taken: _____

DRUG ALLERGIES: _____

PAST SURGERIES: Please list your past surgeries and the date of surgery.

Surgery:	Date:	Surgery:	Date:

MEDICAL HISTORY: (Examples: Hospitalizations, diseases, medical conditions, traumatic injuries.)

Diagnosis:	Date:	Diagnosis:	Date:

MEDICATIONS: Please list medications you are currently taking, and their dosages.

Medication:	Dose :	Medication:	Dose:

Family History – Please check all that apply to you.

- | | | | |
|--|--|---|-----------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Strokes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Cancer | <input type="checkbox"/> Aneurysms | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Disease | |

Do you smoke? Yes No If YES, how much per day? _____

Do you consume alcohol? Yes No If YES, how much per day? _____

If you are female, is there a chance you might be pregnant? Yes No

Authorized signature: I authorize the release of any of my medical information/records necessary to process an insurance claim. I authorize payment of medical benefits to the Austin Ear Clinic and/or Dr. Patrick W. Slater.

Patient Signature (for minor patients, signature of parent/guardian)

DATE