# PQRS Case History Form

***For Patient to Complete***

Please check if you experience any of the following conditions or symptoms.

Patient Name: ______________________

Date of Birth: ______________________

Today's Date: ______________________

| Ear/Hearing (Measure #188) | | |
|---|---|---|
| *Category* | ✓ | *Notes* |
| Hearing Loss | | |
| Gradual Onset | | |
| Sudden Onset | | |
| Fullness/Pressure | | |
| Pain | | |
| Sensitivity to Sound | | |
| Tinnitus | | |
| Cerumen Removal (wax) | | |
| Drainage | | |
| Abnomaly of the ear | | |
| Surgery of the Head or Neck | | |
| Chronic Ear Infections | | |
| Trauma injury to ear | | |
| Family History | | |

| Risk Factors | | |
|---|---|---|
| *Category* | ✓ | *Notes* |
| Recreational Noise Exposure | | |
| Occupational Noise Exposure | | |
| Military Service | | |

| Acute of Chronic Dizziness (Measure #261) | | |
|---|---|---|
| *Category* | ✓ | *Notes* |
| Dizziness | | |
| Disequilibrium | | |
| Imbalance | | |
| Vertigo (Room is spinning) | | |
| Staggering Gait | | |
| History of Falls | | |
| Use of walker, cane, etc. | | |
| Injuries as a result of falling | | |

| Cardiovascular | | |
|---|---|---|
| *Category* | ✓ | *Notes* |
| Heart Attack | | |
| Bypass Surgery | | |
| Stent Placement | | |
| Pacemaker | | |
| Hypertension | | |
| Hypercoagulability | | |
| High Cholesterol | | |
| Peripheral Arterial Disease (PAD) | | |
| Polycythemia | | |

| Endocrine | | |
|---|---|---|
| *Category* | ✓ | *Notes* |
| Diabetes | | |
| Thyroid Disease | | |
| Hypoglycemia | | |

| Neurology | | |
|---|---|---|
| *Category* | ✓ | Notes |
| Migraines | | |
| Stroke | | |
| Multiple Sclerosis | | |
| Parkinsons | | |
| Dementia/Alzheimers/Memory Loss | | |
| Peripheral Neuropathy | | |

| Auto-Immune | | |
|---|---|---|
| *Category* | ✓ | *Notes* |
| Meniere's Disease | | |
| Vasculitis | | |
| RH Arthritis | | |
| Lupus | | |

| Vision/Eye | | |
|---|---|---|
| *Category* | ✓ | *Notes* |
| Cataract(s) | | |
| Glaucoma | | |
| Macular Degeneration | | |
| Retinopathy | | |
| Low Vision | | |

| Mental Health (Measure #134) | | |
|---|---|---|
| *Category* | ✓ | *Notes* |
| Anxiety | | |
| Panic Disorder | | |
| Depression | | |
| Sleeping Problems | | |

| Infectious Diseases | | |
|---|---|---|
| *Category* | ✓ | *Notes* |
| Tuberculosis | | |
| Mononucleosis | | |
| HIV | | |
| Lyme Disease | | |

| Recreational | | |
|---|---|---|
| *Category* | ✓ | *Notes* |
| Drug Usage | | |
| Alcohol | | Circle One: Daily, Weekly, Socially |

| Please provide a copy of your medications or list below. |
|---|
| 1) |
| 2) |
| 3) |
| 4) |