HEALTH HISTORY FORM

NAME: ______________________________ DATE: ______________________

FAMILY PHYSICIAN: ______________________________

MEDICAL/HEARING

Do you have pain/discomfort in your ear? NO____Right__Left____Both___

Do you have you any drainage in your ear NO____Right__Left____Both___

Do you have a history of ear infections? NO____Right__Left____Both___

Do have ringing or other noises in your ear? NO____Right__Left____Both___Constant or intermittent?______________

Have you ever had ear surgery? NO____Right__Left____Both___

Please describe: ______________________________

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the last 24 months? NO__YES___

Have you have any trauma to the head/ears? NO____YES___

Do you have dizziness or vertigo? NO____YES___

Do you have a diagnosis of diabetes? NO____YES___

Do you take any blood thinners? NO____YES___

Is there a family history of hearing loss? NO____YES___If yes, who?______________________

Have you had noise exposure in your lifetime? NO____YES___

If yes, from work/military/hobbies, etc., please specify: ______________________________

Do you think you have a hearing loss? NO____YES___

Have you had your hearing tested before? NO____YES___

Do you currently use a hearing aid? NO____YES___

If yes, how long?:______________________What type:__________________Are you satisfied with it: NO___YES___

Have you seen your physician regarding any of the above? ______________________________

Please describe other medical conditions we should be aware of: ______________________________

CURRENT MEDICATIONS:

NOTES (office use)