# Patient Medical & Audiological History

Complete this form BEFORE coming to your appointment.

Patient's Name: _____ Date of Birth: _____

Reason for today's appointment? _____

_____

**Do you have a history of:**

- ◯Y ◯N Diabetes
- ◯Y ◯N Heart Disease
- ◯Y ◯N Radiation or Chemotherapy
- ◯Y ◯N Surgery in the last 5 years
- ◯Y ◯N Exposure to loud noises
- ◯Y ◯N Ear infections
- ◯Y ◯N Perforated ear drum
- ◯Y ◯N Tinnitus (ringing ears)
- ◯Y ◯N Dizziness/balance problems
- ◯Y ◯N Ear Surgery
- ◯Y ◯N Compromised Immune System

**Do you regularly take:**

- ◯Y ◯N Aspirin
- ◯Y ◯N Blood Thinners
- ◯Y ◯N Diuretics
- ◯Y ◯N Vicodin or OxyContin
- ◯Y ◯N Quinine (tonic water)

Explain all YES items:_____

_____

_____

List all family members that have hearing problems:_____

_____

When was your last hearing examination? ◯ Never ◯ 1-3 Years ◯ Over 3 Years

How long ago did you first notice a problem with your hearing? _____

**Medications:** Please list the medications you take regularly. Include prescription and non-prescription drugs. If you have a list just give us a copy instead of duplicating the information here.

Medication Dosage Times per day Reason for Medication

_____

_____

_____

_____

_____

_____

_____

_____

## Patients: Turn over and complete other side

**Please check the 3 listening situations where better hearing is most important to you:**

☐ Church/Religious meetings ☐ Music ☐ Social Situations ☐ Meetings ☐ TV/Radio

☐ Cell Phone ☐ Regular Phone ☐ Outdoor Sports/Activities ☐ Driving ☐ Travel

☐ Family Communication ☐ Restaurants Other _____

***How is your hearing impacting your life and the life of those around you? Please answer each question below. If possible please have a loved one or close friend complete the Companion Response.***

A= Always S= Sometimes N= Never

| **Does Your Hearing** | **Patient Responses** | **Companion Responses** |
|---|---|---|
| Cause others to complain that the TV or radio is too loud? | ◯A ◯S ◯N | ◯A ◯S ◯N |
| Cause problems when you are in restaurants? | ◯A ◯S ◯N | ◯A ◯S ◯N |
| Cause problems when you are in meetings or church? | ◯A ◯S ◯N | ◯A ◯S ◯N |
| Cause you to feel like others mumble? | ◯A ◯S ◯N | ◯A ◯S ◯N |
| Cause you to ask people to repeat themselves? | ◯A ◯S ◯N | ◯A ◯S ◯N |
| Cause you to hear, but fail to understand what is being said? | ◯A ◯S ◯N | ◯A ◯S ◯N |

# STOP - DO NOT COMPLETE ANYTHING BELOW THIS LINE
# OFFICE USE ONLY

**Otoscopy Rt**_____ **Lt**_____

**Audiology & Medical Notes** _____

_____

_____

_____

**Life Style & Hearing Aid Notes** _____

_____

_____

_____

I have reviewed the patient's medical and audiological history as well as their medications

_____ _____

Provider's Signature Date