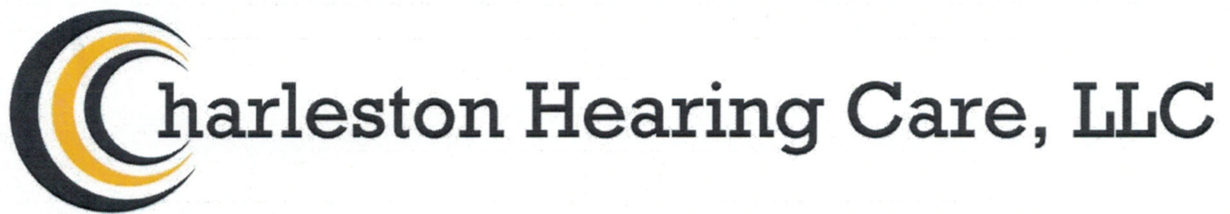

History Questionnaire

Name____________________________________Date of Birth ____________Age ______

Referring Doctor or Primary Care Physician _______________________________________

Would you like us to send a report to your doctor? ______________Yes ______________No

What is the reason for today's visit? ____

AUDIOLOGIC HISTORY

Are you, or have you, experienced any of the following conditions?

History of chronic ear infections as a child or adult? ____________________________________

History of ear surgery? _____________If so, right or left ear, and when? ____________________

History of trauma to the head? ____

Ringing in your ears? (ringing, buzzing, hissing) _______________________________________

If yes, which ear? ___________How frequent? ______________Since when? __________

Dizziness, vertigo, or loss of balance? ____

If yes, please describe when it began, the duration, and how often it occurs _____________

____

Otalgia (Ear Pain)? ____

Fullness in your ears? ____

Sinus or allergy problems? ____

Have you experienced any extreme sensitivity to sound? ________ Distortion of sound? ________

Family history of hearing loss? ____

History of noise exposure? ____

Have you ever had your hearing tested before? _______________________________________

If so, when was the last time you were tested? __________________________________

Have you ever worn a hearing aid? ____

MEDICAL HISTORY

How is your general health? ____

Recent hospitalization/surgeries? ____

____

Have you had or currently have any of the following:

__________Diabetes

__________Thyroid Disorders

__________Kidney Disease

__________Visual Problems

__________Heart Disease

__________High Blood Pressure

__________Arthritis

__________Head Trauma

__________Stroke

__________Cancer

__________Pacemaker

__________Depression

__________Blood Disorders

__________Respiratory Disorders

__________Meningitis

__________HIV/Syphillis

Please list any chronic conditions, other than those listed above, for which you have been, or are Currently being treated? ____

____

Please list any medications that you are currently taking:

MEDICATION	DOSAGE/HOW OFTEN	TAKEN FOR	PRESCRIBING DOCTOR

Patient's Signature ______________________________ Date ______________