# Confidential Patient History

**Patient name:** ___________________________ **Date:** ____________________

**Marital Status**: Single Married Divorced Widow Domestic Partner

**Current Employment**: Full Time Part Time Retired Unemployed Stay at Home Student

Do you currently use tobacco? **YES** **NO**

If Yes, what do you smoke? Cigarettes cigars pipe smokeless other: ______________

If Yes, amount/day: _______________________________________________________

Do you currently drink alcoholic beverages? **YES** **NO**

If yes, how often? Daily Weekly Monthly Occasionally Rarely

## Audiologic History

Do you experience hearing loss? **YES** **NO** If so, which ear? **RIGHT** **LEFT** **BOTH**

If you experience hearing loss, which best describes it? **Gradual** **Fluctuating** **Sudden**

When did you first notice your hearing loss? _____________________________________________

What do you think is the cause of your hearing loss? _______________________________________

Ever seen an Ear/Nose/Throat doctor? **YES** **NO** If Yes, When? __________ Who? ________________

Ear Surgery? **YES** **NO** If yes, please describe: _____________________________________________

Ever had hearing tested before? **YES** **NO** If Yes, When? ____________ Who? _______________

Do you currently wear hearing aids? **YES** **NO**

If yes, how long? **_______RIGHT______ LEFT___________BOTH___________**

If no, have you ever tried hearing aids? YES NO

**Please check all medical condition that apply:**

**_____Developmental Disorders/Delays** If checked, please explain:_________________________________

**_____Dizziness or Unsteadiness** If checked, is it accompanied by: Vomiting Nausea Ear Noises

_____**Ear Deformity** If checked, Right ear Left ear Both ears

_____**Ear Drainage** If checked, Right ear Left ear Both ears

_____**Ear Pain** If checked, Right ear Left ear Both ears

_____**History of Ear Infections** If checked, Right ear Left ear Both ears

_____**Previous Ear Surgery** If checked, Right ear Left ear Both ears

_____**Tinnitus/Noises in Ears** If checked, Right ear Left ear Both ears Frequency?________

_____**History of Wax build up** If checked, Right ear Left ear Both ears

_____**Family History of Hearing Loss** If checked, who? ______________________________

_____**History of Noise Exposure** If checked, Please describe: ________________________________

Please check any of the following that you currently have or have had in the past:

❒ Arthritis ❒ Heart Trouble ❒ Measles ❒ Parkinson's

❒ Bell 's palsy ❒ High Blood Pressure ❒ Mumps ❒ Diabetes

❒ Neurological ❒ Stroke/TIA ❒ Head Injury ❒ Vascular Problems

❒ Shingles ❒ Genetic Disorder

❒ Cancer (Type__________Current Treatment______________________________ )

❒ Blood Disorders

❒ Other Medical Conditions you would like to make us aware of ______________

________________________________________________________________

Current Medications/dosages (OTC and Prescriptions):

________________________________________________________________

________________________________________________________________

Please check all that apply: _____**Eye Problems/Blurred Vision** _____**Nose, Throat, Mouth Problems**

_____**Neurologic Symptoms (numbness, headaches, seizures, muscle weakness)**

_____**Psychiatric Issues (depression, anxiety, compulsions)**_____**Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency)**