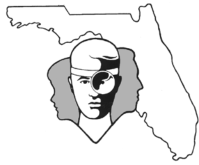

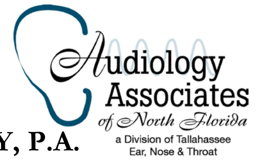

TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.
AUDIOLOGY ASSOCIATES OF NORTH FLORIDA

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Tallahassee, FL 32308
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NEW PATIENT ADULT HEARING HISTORY

PATIENT NAME: ____________________________________ **DOB**: ___________ **DATE**: _______________

WHAT IS YOUR PRIMARY REASON FOR TODAY'S VISIT? ____

____

MEDICAL HISTORY

PLEASE MARK ALL RESPONSES THAT APPLY TO YOU:

ACOUSTIC NEUROMA	____	EAR INFECTION	____	PARKINSON'S DISEASE	____
AIDS/HIV	____	HIGH BLOOD PRESSURE	____	RHEUMATIC FEVER	____
ASTHMA	____	HEAD INJURY	____	SINUS PROBLEMS	____
AUTOIMMUNE DISORDER (type ______________)	____	HEART ATTACK	____	SEASONAL ALLERGIES	____
		HEPATITIS/LIVER TROUBLE	____	STROKE	____
CANCER (type ___________)	____	HIGH FEVER	____	SUDDEN CHANGES IN HEARING	____
CONVULSIONS/EPILEPSY	____	KIDNEY PROBLEMS	____		
DEMENTIA	____	MENINGITIS	____	THYROID DISEASE	____
DIABETES	____	MENIERE'S DISEASE	____	OTHER_______________________	

MEDICATIONS ______ None ______ List attached

(Please make sure to include over-the-counter medications, vitamins and herbal remedies)

	Name	Dose (i.e. mg, ml)		Name	Dose (i.e. mg, ml)
1.	________________	__________	6.	________________	__________
2.	________________	__________	7.	________________	__________
3.	________________	__________	8.	________________	__________
4.	________________	__________	9.	________________	__________
5.	________________	__________	10.	________________	__________

ALLERGIES ______ None______ List attached

	Allergy	Reaction
1.	________________	__________
2.	________________	__________
3.	________________	__________
4.	________________	__________

EAR RELATED SURGERIES

PLEASE MARK ALL RESPONSES THAT APPLY TO YOU:

MIDDLE EAR/EAR DRUM SURGERY (i.e. ear drum, mastoid, stapes, ossicular chain, cholesteatoma)	____
PE TUBES	____
ACOUSTIC NEUROMA	____

SOCIAL HISTORY

SMOKE/VAPE: NEVER ____ CURRENTLY ____ PREVIOUSLY ____ NUMBER OF PACKS PER DAY? _____

DRINK ALCOHOL: NEVER ____ CURRENTLY ____ PREVIOUSLY ____ NUMBER OF DRINKS PER DAY? _____

RECREATIONAL DRUG USE: NEVER ____ CURRENTLY ____ PREVIOUSLY _

STEROID USE: NEVER ____ CURRENTLY ____ PREVIOUSLY

HEARING

HEARING LOSS RIGHT ____ LEFT ____ NONE ____

WHEN DID YOU FIRST NOTICE A PROBLEM? ____________________________________

RINGING/SOUNDS IN THE EAR RIGHT ____ LEFT ____ NONE ____

IF YES, PLEASE DESCRIBE: ____

NOISE EXPOSURE:

MILITARY WORK	YES	____	NO	____	IF YES, HOW LONG? ____________________
FACTORY WORK	YES	____	NO	____	IF YES, HOW LONG? ____________________
FIRE GUNS	YES	____	NO	____	
WOODWORKING	YES	____	NO	____	
LOUD MUSIC	YES	____	NO	____	
YARD EQUIPMENT	YES	____	NO	____	
MACHINERY	YES	____	NO	____	

DO YOU WEAR HEARING PROTECTION? NO _____ OCCASIONALLY ____ ALL THE TIME _____

PAIN IN THE EAR RIGHT ____ LEFT ____ NONE ____

FULLNESS/PRESSURE IN THE EAR RIGHT ____ LEFT ____ NONE ____

DIZZINESS/IMBALANCE YES ____ NO ____

WHEN DO YOU EXPERIENCE THE MOST TROUBLE HEARING? ____

DO YOU HAVE A FAMILY MEMBER WITH HEARING LOSS? YES ____ NO _____

IF YES, WHO? ____________________________________

IF YOU ARE IDENTIFIED WITH HEARING LOSS, ARE YOU READY FOR HELP? ________________________________

HAVE YOU EVER WORN HEARING AIDS? YES _____ NO _____

IF HEARING AIDS ARE RECOMMENDED, ON A SCALE OF 1 TO 10, ARE YOU READY TO PURSUE HEARING AIDS AT THIS TIME?

NOT READY 1 2 3 4 5 6 7 8 9 10 START NOW

HOW DID YOU CHOOSE OUR CLINIC FOR YOUR HEARING CARE? FRIEND/FAMILY REFERRAL ___
ONLINE REVIEWS___ DOCTOR REFERRAL ___ PRINT AD ___ RADIO ___ SEMINAR ___ TV AD ___
OTHER: __________________

I have completed this medical/audiological history form and to the best of my knowledge, it is complete and accurate. I understand that this document will be used for medical decision-making.

____

Patient Signature

____

Date