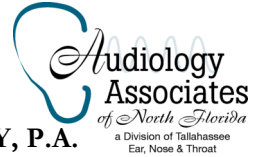




TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.
AUDIOLOGY ASSOCIATES OF NORTH FLORIDA



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ADULT HEARING HISTORY

PATIENT NAME: _____

DATE: _____

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

MEDICAL HISTORY

PLEASE MARK ALL RESPONSES THAT APPLY TO YOU:

AIDS/HIV
 ASTHMA
 CANCER (type _____)
 CONVULSIONS, EPILEPSY
 DIABETES
 HEART ATTACK

HIGH BLOOD PRESSURE
 HEAD INJURY
 HEPATITIS, LIVER TROUBLE
 HIGH FEVER
 KIDNEY PROBLEMS

MENINGITIS
 RHEUMATIC FEVER
 STROKE
 THYROID DISEASE
 OTHER _____

LIST ALL CURRENT MEDICATIONS: _____

LIST ALL PREVIOUS SURGERIES AND DATES: _____

SOCIAL HISTORY

SMOKE NEVER CURRENTLY PREVIOUSLY NUMBER OF PACKS PER DAY? _____
 DRINK ALCOHOL NEVER CURRENTLY PREVIOUSLY NUMBER OF DRINKS PER DAY? _____
 RECREATIONAL DRUG 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: _____

FULLNESS/PRESSURE IN THE EAR	RIGHT	LEFT	NONE
DIZZINESS	YES	NO	
NOISE EXPOSURE:			
MILITARY WORK	YES	NO	IF YES, HOW LONG? _____
FACTORY WORK	YES	NO	IF YES, HOW LONG? _____
FIRE GUNS	YES	NO	
WOOD WORKING	YES	NO	
LOUD MUSIC	YES	NO	
YARD EQUIPMENT	YES	NO	
DO YOU WEAR HEARING PROTECTION?	NO	OCCASIONALLY	ALL THE TIME

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 HEAR ABOUT OUR CENTER? FRIEND DOCTOR REFERRAL NEWSPAPER
 TV AD RADIO SEMINAR TELEPHONE BOOK
 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