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

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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:

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	___		
DIABETES	___	MENINGITIS	___	THYROID DISEASE	___
EAR INFECTION	___			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. _____	_____
5. _____	_____

EAR RELATED SURGERIES AND DATES

Surgery	Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

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: _____

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	____	
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 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