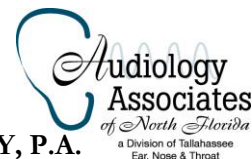




**TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.**  
**AUDIOLOGY ASSOCIATES OF NORTH FLORIDA**



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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 _____
CANCER (type _____)	HEPATITIS/LIVER TROUBLE _____	STROKE _____
CONVULSIONS/EPILEPSY _____	HIGH FEVER _____	SUDDEN CHANGES _____
DIABETES _____	KIDNEY PROBLEMS _____	IN HEARING _____
EAR INFECTION _____	MENINGITIS _____	THYROID 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

**EAR RELATED SURGERIES AND DATES**

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