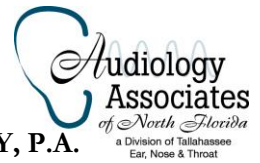




TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.
AUDIOLOGY ASSOCIATES OF NORTH FLORIDA



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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 _____	MENINGITIS _____
ASTHMA _____	HEAD INJURY _____	RHEUMATIC FEVER _____
CANCER (type _____) _____	HEPATITIS, LIVER TROUBLE _____	STROKE _____
CONVULSIONS, EPILEPSY _____	HIGH FEVER _____	THYROID DISEASE _____
DIABETES _____	KIDNEY PROBLEMS _____	OTHER _____
HEART ATTACK _____		

MEDICATIONS _____ None _____ List attached

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

Name	Dose	Name	Dose
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	____		

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

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

DIZZINESS 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