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

	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	____	

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