

Southwest Florida Center For Hearing and Balance



Patient name _____ Male _____ Female _____

Married Single Divorced Widowed Date of Birth _____ Age _____

Place of work _____ Social Security Number _____

Email address _____

Home Address _____

City: _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

MEDICAL HISTORY

YES NO Have you seen a doctor in the past 6 months? (Dr. _____)

YES NO Have you seen a doctor specializing in diseases of the ear? (Dr. _____)

YES NO Have you ever had your hearing tested?
(When _____ ? By whom? _____)

YES NO Have you ever had any type of ear surgery?
(What type? _____ Dr. _____)

List Major Medical Problems

| | | | | | |
|-------------------|--------------------------|---------------------|--------------------------|------------------|--------------------------|
| Asthma | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> |
| Bladder Disease | <input type="checkbox"/> | Hayfever | <input type="checkbox"/> | Prostate Disease | <input type="checkbox"/> |
| Bleeding Problems | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | Reflux | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | Stomach Ulcers | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | Seizures | <input type="checkbox"/> |
| | | HIV/ Aids | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | | | | |

(If yes, Where? _____)

List Medications you now take _____

List Known Drug/Medication Reactions _____

Who can we thank for referring you to our practice? _____

Who may we discuss your test results and your condition with other than yourself?

Signature of Patient _____ Date _____

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HEARING HISTORY

Today's Date _____

Patient name _____ Date of Birth _____

ABOUT YOUR EARS: Do you have any of these symptoms?

- | | | |
|-----|----|-----------------------------------------------------|
| YES | NO | Deformity of the ear |
| YES | NO | Drainage from the ear |
| YES | NO | Sudden or rapid loss of hearing in the past 90 days |
| YES | NO | Acute or chronic dizziness |
| YES | NO | Pain in your ears |
| YES | NO | Noises, ringing, rushing or roaring in your ears |

Which is your better ear? Same Right Left

ABOUT YOUR HEARING: Do you experience difficulty with the following?

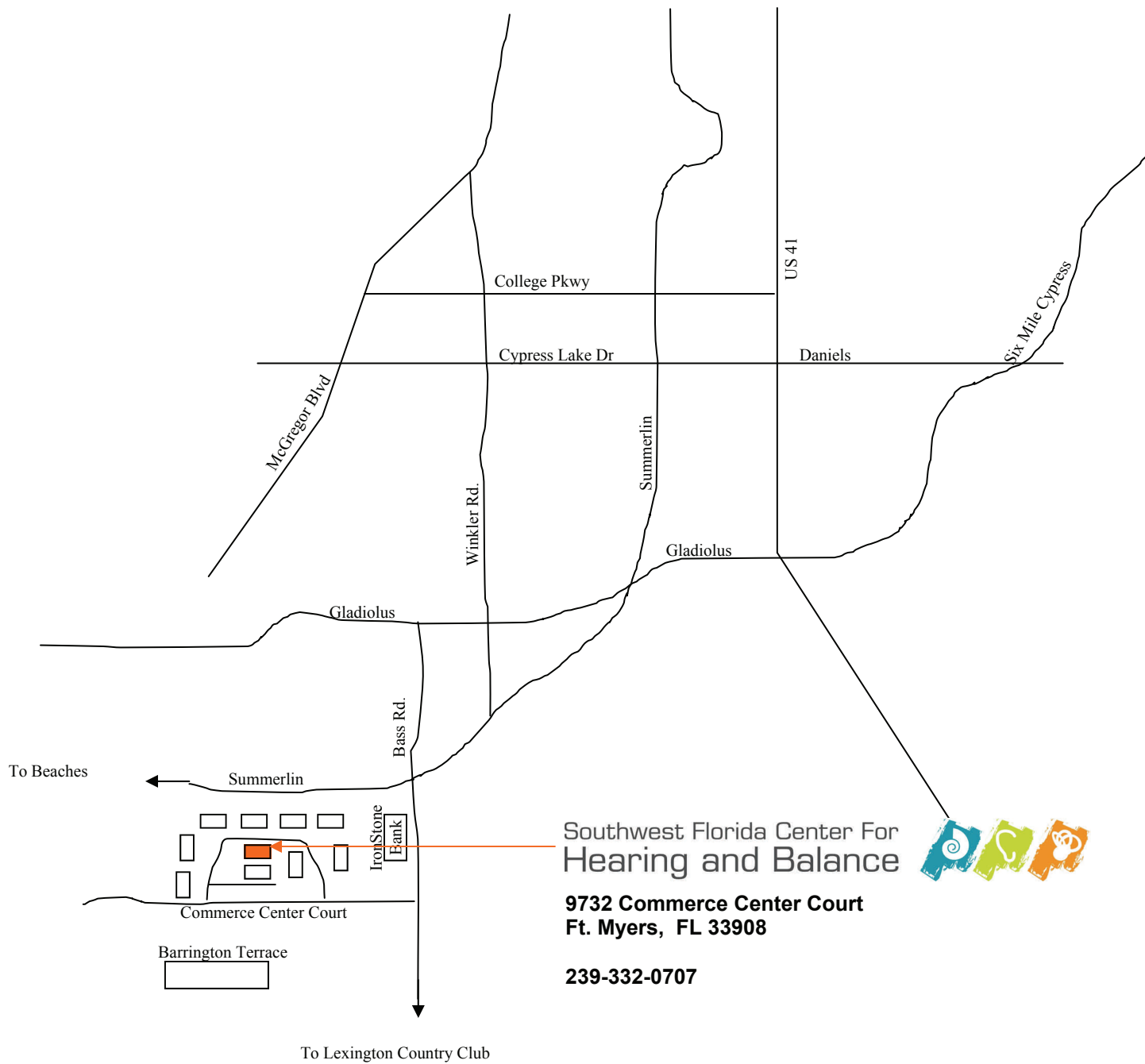
- | | | |
|-----|----|-------------------------------------------------------|
| YES | NO | Understanding conversation |
| YES | NO | Hearing in a crowd |
| YES | NO | Hearing on the telephone |
| YES | NO | Complaints from friends and family about your hearing |

If you feel you have a hearing problem, how long have you had it? _____

YES NO Does anyone in your family have hearing loss ?
(If so, what relationship? _____)

YES NO Have you ever worn a hearing aid?
If yes, what have been your experiences? _____

YES NO If a hearing loss is found are you ready to take steps in rehabilitation?



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