Appalachian Hearing and Speech Center

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Confidential Patient History - Dated:

Patient Name: **Birth Date:**
Address:
City: **State:** **Zip Code:**

Please complete the following:

MEDICAL HISTORY:

Yes No Have you seen a doctor in the past six months? (Dr. _____)
Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, give date _____
Yes No Have you ever had your hearing tested?
If yes, give date _____ Results _____
Yes No Have you ever had any type of ear surgery?
If yes, type of surgery _____(Dr. _____)
Yes No Is there family history of hearing loss? (Parents, Grandparents, etc)
Yes No Are you diabetic:
Yes No Do you take medicine every day?
For what condition? _____
List medications and what you take them for:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Yes No Do you have any other medical conditions?
If yes, explain _____
Yes No Are you hypertensive?; Yes No Nervous?; Yes No Have a heart condition?

ABOUT YOUR EARS: Do you have or have you had any of these symptoms?
Yes No Deformity of the ear
Yes No Drainage from the ear or ear infection When?_____
Yes No Sudden or rapid loss of hearing in the past 90 days
Yes No Acute or chronic dizziness When? _____
If so do you or the room spin? _____
Yes No Do you have tinnitus (noise in your ear)?
If so describe what type noise and which ear, or is it in both ears? _____
Yes No Which is your poorer ear? Same Right Left
Yes No Have you ever seen a doctor for wax removal? When? _____
Yes No Do you ever have pain in your ears?
Yes No Have you ever had a hole in your ear drum (ruptured or perforated ear drum)?
What do you think caused your hearing problem: _____