BAYSIDE AUDIOLOGY & HEARING AIDS

Audiologic and Medical History

Appointment Date: _______________

Patient Name: ____ Date of Birth: _______________Age:________

Chief Complaint: (Please check all that apply)

Hearing Loss: ____Right, ____Left; ____Sudden, ____Gradual, ____ In Quiet, ____ In Noise

Tinnitus (Ringing): ____Right, ____Left ____ Difficulty Hearing on Telephone

How long have you noticed this difficulty? __________________________ Date of Last Hearing Test: ____________________

Do you wear hearing aids? ____

Do you have any pain or drainage from your ears? Left Right Both No

Do you have any difficulties with balance or Vertigo? Yes No Please describe: __________________________________

Have you experienced extreme sensitivity to sound? Yes No Please describe: __________________________________

Have you had any ear surgeries? Left Right No Date: _________________

Have you had any recent colds? Yes No If so, when? __________________

Do you have sinus/allergy/hay fever problems? Yes No Please explain: ______________________

Is there a family history of hearing loss? Yes No If yes, who? ______________________________

Do you have any history of noise exposure? Yes No If yes, when and to what? _______________

CURRENT MEDICATIONS:

Name of medication	**Dosage**	**What is the medication taken for**	**Prescribing Physician**

Do you have (currently or in the past) any of the following:

___Heart problems (cardiac)/ Pacemaker
___Diabetes / Hypoglycemia
___Vascular Problems
___Endocrine or Hormonal Problems
___Arthritis
___Head injuries
___Neurologic issues
___Kidney Disease

___Depression
___High Blood Pressure
___Stroke
___Blood Disorder
___Cancer
___Thyroid disorder
___HIV/Syphilis
___Meningitis

___Hyperlipidemia (High cholesterol)
___COPD
___Memory problems
___Otosclerosis
___Meniere's Disease
___Any disorder of the outer, middle, or inner ear
___Enrolled in Hospice Care

Have you used a tobacco product (cigarette/cigar/smokeless tobacco) one or more times in the past 24 months? Yes/ No
-If yes, how often have you used a tobacco product in the past 24 months? _______________