Adult Medical History

Name: _____ DOB: / / Date: / / ID _____

Chief complaint**:** _____
_____

How long? _____ Gradual or Sudden? _____ Better hearing ear: R / L

Please list the three situations where you have the most difficulty hearing
1. _____
2. _____
3. _____

Do you have hearing difficulty with: Telephone or Television

Do you have:
Pain in your ear? Y / N _____
Drainage from your ears? Y / N _____
Facial tingling/numbness? Y / N Taste disorder? Y / N
Loudness discomfort? Y / N _____

Do you have Tinnitus (Ringing in ears)? Y / N R / L Is it constant or occasional?
Describe how it sounds _____
Do you have Dizziness? Y/ N Spinning/off balance? Nausea Y / N
How long does it last? Seconds /minutes /hours /days /weeks /constant?
What seem to make you dizzy?; Changes in Position Loud Sounds Pressure Motion Other
_____
Do you currently use hearing aids? If yes:
Current HA's; L/R/B; MFG/model _____/_____
Provider _____
How long have you used them? _____
Are current hearing aid(s) helpful? Not helpful /somewhat helpful / very helpful

Family History of Hearing Loss: Mother/ Father/ Children/ other _____

Noise Exposure History
Occupational Y / N _____
Recreational Firearms: Y / N Pistol / rifle RH /LH HP's? Motorcycle Y / N
Other: _____
Were you in the military? Y / N _____
Do you use tobacco products? Y N (Brochure given Y N)
Are you Diabetic? Y / N If yes, How long: _____ Do you use insulin? Y / N
Have you had ear surgery? Y / N _____
Have you had your hearing evaluated before, if so by whom**?** _____

Have you been diagnosed with an ear related medical problem? Y / N

(Continued on back)

Please check all medical symptoms that apply:

- Eye Problems (such as blurred vision, pain): Yes No
- Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain): Yes No
- Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations): Yes No
- Respiratory Symptoms (such as shortness of breath, cough, wheezing): Yes No
- Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain): Yes No
- Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma): Yes No
- Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness): Yes No
- Psychiatric Issues (such as depression, anxiety, compulsions): Yes No
- Endocrine Symptoms (such as frequent urination, hot flashes): Yes No
- Hemotologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands): Yes No
- Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency): Yes No

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Comments Related to Review of Symptoms:

_____
_____
_____

Medications list: _____Attached _____Not available

Have you ever had:
IV antibiotics Y / N _____ Chemo therapy Y / N _____
Pain treatment with narcotics: Y / N _____
Pain treatment with NSAIDs: Y / N _____

Notes:

_____
_____
_____
_____
_____

Examiner: _____