

HISTORY FORM

Name: _____ DOB: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip _____
 Telephone: _____ Email: _____

Reason for today's visit _____

Otologic History

(Ear problem includes: ear infections, ear aches, draining ears, medicine taken for ear problem, doctor noticed fluid behind the eardrum, hole in eardrum, etc.)

1. How many ear problems have you had?
 None _____ 1-2 _____ 3-5 _____ 6-10 _____ 10 or more _____
2. Have you had an ear problem in the last 6 months? Yes No
 If yes, when? _____ What type of ear problem? _____
 Was medication given? Yes No
3. Do you have any of the following?
 - Frequent runny nose Yes No
 - Frequent colds or sinus infections ... Yes No
 - Allergies Yes No
 - Ringing or buzzing in the ear(s) Yes No
 - Dizziness Yes No
4. Have you ever been seen by and Ear, Nose, and Throat (ENT) doctor? Yes No
 If yes, which doctor? _____ When? _____
5. Have you ever had any ear surgery? Yes No
6. Have you previously had your hearing tested by an audiologist? Yes No
 If yes, by whom? _____ When? _____
 What were the results? _____
7. Do you have any permanent hearing loss? If yes, describe Yes No
 Have you ever used amplification? Yes No

Family History

1. Is there a family history of hearing loss? Yes No
If yes, explain.

General Health History

1. Do you have any major medical conditions? Yes No
If yes, explain.

2. Are you taking any medications? Yes No
If yes, please list.

3. Have you had any serious illnesses or accidents? Yes No
If yes, describe.

Listening and Understanding

1. Do you think you have a problem listening or understanding speech? Yes No
If yes, give examples.

How long have you been aware of this problem?