

## Medical History

(This information is for official and medical confidential use only and will not be released to unauthorized persons.)

<b>LAST NAME, FIRST NAME, MIDDLE INITIAL</b>	<b>BIRTHDATE (MM/DD/YYYY)</b>	<b>TODAY'S DATE (MM/DD/YYYY)</b>
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Main reason for visit ( <i>Indicate below</i> )	
Hearing Loss	<input type="checkbox"/>
Dizziness (vertigo)	<input type="checkbox"/>
Ringing in ears (tinnitus)	<input type="checkbox"/>
Other _____	<input type="checkbox"/>

Please check box:	Yes	No			
Do you hear but have trouble understanding others?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a noisy work environment?	<input type="checkbox"/>	<input type="checkbox"/>
Do people tell you that you have the TV turned up too loud?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use hearing protection when in noise?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble hearing on the telephone?	<input type="checkbox"/>	<input type="checkbox"/>	What percent of the time _____%		
Do you have trouble hearing in a noisy room?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a noisy work environment in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid social situations because you can't hear?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, for how long _____?		
Do you have a prescription hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have noisy hobbies or recreation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you now or have you had ear pain?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, do you use hearing protection?	<input type="checkbox"/>	<input type="checkbox"/>
Ear Drainage	<input type="checkbox"/>	<input type="checkbox"/>	What percent of the time _____%		
Dizziness/Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	Do you use firearms?	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in one or both ears	<input type="checkbox"/>	<input type="checkbox"/>	Are you right or left handed? (please circle)	R	L
Sudden hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many rounds a year _____.		
Fluctuating Hearing Loss (comes and goes)	<input type="checkbox"/>	<input type="checkbox"/>	Do you use power tools?	<input type="checkbox"/>	<input type="checkbox"/>
Fullness or Discomfort in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Do you work with heavy machinery?	<input type="checkbox"/>	<input type="checkbox"/>
Wax (Cerumen) or Objects in Ear Canal	<input type="checkbox"/>	<input type="checkbox"/>	Do you ride motorcycles?	<input type="checkbox"/>	<input type="checkbox"/>
Have you seen a Doctor for ear problems?	<input type="checkbox"/>	<input type="checkbox"/>	Do you listen to loud music (including headphones)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had Ear/Head/Neck surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulties wearing ear plugs?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of hearing loss in the family?	<input type="checkbox"/>	<input type="checkbox"/>	Have you worn ear hearing protection today?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	Have you served in the military?	<input type="checkbox"/>	<input type="checkbox"/>
Current head cold or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, length of service _____.		

ALLERGIES:
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CURRENT MEDICATIONS:
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*Space reserved for Doctor's comments*

Reviewed \_\_\_\_\_

<b>LAST NAME</b>	<b>FIRST NAME</b>
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Have you ever had or do you currently have:	YES	NO
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headache	<input type="checkbox"/>	<input type="checkbox"/>
A head injury	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Seizures, convulsions, or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
A period of unconsciousness or concussion	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss or amnesia	<input type="checkbox"/>	<input type="checkbox"/>
Other neurological symptoms or problems	<input type="checkbox"/>	<input type="checkbox"/>

Severe tooth or gum trouble	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid trouble or goiter	<input type="checkbox"/>	<input type="checkbox"/>
Blurred or Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Loss of vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses or glasses	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>

Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Been prescribed or used an inhaler	<input type="checkbox"/>	<input type="checkbox"/>
A chronic cough or cough at night	<input type="checkbox"/>	<input type="checkbox"/>
Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chronic or frequent colds	<input type="checkbox"/>	<input type="checkbox"/>

Pain or pressure in the chest	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation, pounding heart or abnormal heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble or murmur	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever applied for or received pension or compensation for any disability or injury?	<input type="checkbox"/>	<input type="checkbox"/>
Is an action currently pending for pension or compensation for any disability or injury?	<input type="checkbox"/>	<input type="checkbox"/>
Recent unexplained weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Growth or Cyst	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Any illness or injury other than those already noted?	<input type="checkbox"/>	<input type="checkbox"/>

Frequent trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Used illegal drugs or abused prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>

*Space Reserved for Doctor's Comments*