

CARY AUDIOLOGY ASSOCIATES, PLLC

Medical History

Name _____ Date of Birth _____ Age _____

Referring Doctor or Primary Care Physician _____

Would you like us to send a report to your doctor? _____ Yes _____ No

What is the reason for today's visit? _____

How is your general health? _____

Recent hospitalizations/surgeries? _____

Have you had or currently have any of the following:

High blood pressure	Heart Disease	Stroke
Arthritis	Pacemaker	Kidney disease
Cancer	Diabetes	Vision problems

Please list any medications that you take: _____

History of chronic ear infections as a child or adult? _____

History of ear disease/ear surgeries? _____

Family history of hearing loss? _____

History of noise exposure? _____

History of trauma to the head? _____

Do you have sinus or allergy problems? _____

Do you have any ringing in your ears? (ringing, buzzing, hissing) _____

If yes, which ear? _____ How frequent? _____ Since when? _____

Do you have dizziness, vertigo, or loss of balance? _____

If yes, please describe when it began, the duration, and how often it occurs _____

Have you ever had your hearing tested before? _____

If so, when was the last time you were tested? _____

Have you ever worn a hearing aid? _____

Patient's Signature _____ Date: _____