CARY AUDIOLOGY ASSOCIATES, PLLC

115 Parkway Office Court, Suite 100
Cary, North Carolina 27518

PATIENT 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? _____

AUDIOLOGIC HISTORY

Are you, or have you, experienced any of the following conditions?

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

History of ear surgery?_____ If so, right or left ear, and when?_____

History of trauma to the head? _____

Ringing in your ears? (ringing, buzzing, hissing) _____

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

Dizziness, vertigo, or loss of balance? _____

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

_____

Otalgia (or ear pain)?_____

Fullness in your ears?_____

Sinus or allergy problems? _____

Have you experienced any extreme sensitivity to sound?_____Distortion of sound?_____

Family history of hearing loss? _____

History of noise exposure? _____

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? _____

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MEDICAL HISTORY

How is your general health? _____

Have you used tobacco within the last 2 yrs?_____

Recent hospitalizations/surgeries? _____

_____

Have you had or currently have any of the following:

_____Arthritis
_____Blood Disorders
_____Cancer
_____Pre-diabetes/Diabetes
_____Head Trauma
_____Heart/Vascular Disease
_____High Blood Pressure
_____Pacemaker
_____ Blood Disorder
_____Kidney Disease
_____Meningitis
_____Stroke
_____Vascular Problems
_____Visual Problems
_____HIV/Syphilis
_____Depression

Please list any chronic conditions, other than those listed above, for which you have been, or are currently being treated? _____
_____

Please list any medications that you are currently taking:

Medication	Dosage/How Often	Taken For	Prescribing Doctor

Patient's Signature _____ Date: _____