HEALTH HISTORY FORM

Please note, this form contains sensitive health information. Keep this in a safe place and do not share with anyone outside of your provider's office.

Today's Date:	**Full Name:**	**Date of birth:**

Phone:	**Address:**

Referred by:	**Reason for visit:**

Primary Care Physician (Name and Phone):

Health History: please check all that apply

- ☐ Diabetes
- ☐ Heart Problems
- ☐ Chemotherapy
- ☐ Migraines
- ☐ Sleep Apnea
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ IV Antibiotics
- ☐ Radiation
- ☐ Other (please list)

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Hearing Health History: please check all that apply

- ☐ Hearing loss
- ☐ Family History of Hearing Loss
- ☐ Pain in Ears
- ☐ Ringing or Buzzing in Ears
- ☐ Ear Infections
- ☐ Ear Surgery
- ☐ Noise Exposure
- ☐ Type of Noise
- ☐ Hearing Aids
- ☐ Other (please list)

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Do you have any of the following: please check all that apply

- ☐ Trauma/injury to ear
- ☐ Ear drainage (in last 90 days)
- ☐ Sudden or rapidly progressive hearing loss (in last 90 days)
- ☐ Dizziness
- ☐ Hearing loss in one ear
- ☐ Ringing or buzzing in one or both ears
- ☐ Ear Pain

Medication History: please list all medications you are currently taking

Medication:	Dose:	Reason for Taking:
Medication:	Dose:	Reason for Taking:
Medication:	Dose:	Reason for Taking:
Medication:	Dose:	Reason for Taking:
Medication:	Dose:	Reason for Taking:
Medication:	Dose:	Reason for Taking: