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## **ADULT HEARING CASE HISTORY – CONFIDENTIAL PATIENT INFORMATION**

Patient Name		Date of Birth	
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Email		@	
Primary Care Physician		Phone	
Reason for today's visit			
How did you hear about our practice?			
Emergency Contact		Phone	
Address		Relationship to Patient	
Allergies			
Please check any of the following that you currently have or have had in the past:			
Arthritis Asthma Bell's Palsy Diabetes Head Injury Heart Trouble Hepatitis High Blood Pressure HIV  Malaria Measles Meningitis Mumps Neurological Parkinson's Scarlet Fever Stroke/TIA Visual Trouble			
Please provide a complete list of the medications you are taking including reason you are taking it and dosing information			
Have you been seen by a physician wit	hin the past 6 months? Yes	]No	
Do you have any of the following symptoms? Pain or discomfort in either ear			
Have you ever had surgery on either o	r both of your ears? Yes No	0	
Have you ever had an ear infection?  Yes No If yes, please indicate: As a child As an adult			
Have you even been exposed to loud noise, either recently or in the past?   Yes   No			
If yes, please mark all that ap  ☐ Jet Engines ☐ Factory N	· · <del>_</del>	ools Music Military Hun	ting/Shooting