Physicians Hearing Care

A Division of Ear, Nose, and Throat Consultants of East Tennessee

Confidential Patient History

Date:

Patient Name:

Birth Date:

MEDICAL HISTORY:

Yes No Have you seen a doctor in the past six months? Dr. _____

Are you hypertensive? Yes No Have a heart condition? Yes No Have diabetes? Yes No

Yes No Do you have any other medical conditions?

If yes, explain _____

Yes No Do you take medication every day?

If yes, explain _____

ABOUT YOUR EARS:

Yes No Have you seen a doctor specializing in diseases of the ear?

If yes, give date: _____ And whom: _____

Yes No Have you ever had your hearing tested?

If yes, give date: _____ And by whom: _____

Yes No Have you ever had any type of ear surgery?

If yes, type of surgery: _____ And by whom: _____

Yes No Deformity of the ear

Yes No Drainage from the ear

Yes No Sudden or rapid loss of hearing in the past 90 days

Yes No Acute or chronic dizziness

Yes No Have you ever seen a doctor for wax removal?

Yes No Do you ever have pain in your ears?

Yes No Do you have trouble understanding conversation?

Yes No Do you have trouble hearing in a crowd?

Yes No Do you have trouble hearing on the telephone?

Yes No Does anyone in your family have a hearing problem? Whom:

Yes No Have you ever worn a hearing aid?

Yes No Do you have ringing in your ears?

Who referred you to us? _____

Signature: _____