SOUTHSIDE HEARING CENTER

Adult Medical Questionnaire

PATIENT NAME	DATE OF BIRTH	TODAY'S DATE

WHY ARE YOU HAVING YOUR HEARING EVALUATED TODAY?

- Do you **SMOKE**? Yes No
- Do you have a **FAMILY HISTORY** of hearing loss? Yes No
- Do you notice a **DIFFERENCE IN HEARING** between the ears? Yes No
  If yes, which ear is the **BETTER** hearing ear? Left Right
- Do you have **RINGING**, buzzing, hissing, roaring, thumping, or other sounds in your ear(s)? Yes No
  If yes, which ear? (circle both if appropriate) Left Right
- Do you have **PAIN**, pressure or fullness in your ear(s)? Yes No
  If yes, which ear? (circle both if appropriate) Left Right
- Do you have **WAX** problems? Yes No
- Do you have itching in the ears? Yes No
- Do you have a history of **NOISE** exposure? Yes No
  If yes, did/do you use hearing protection? Yes No
- Do you have **DRAINAGE** from the ears? Yes No
  If yes, which ear? (circle both if appropriate) Left Right
- Do you have **DIZZINESS**, imbalance or lightheadedness? Yes No

  Describe:_____ Can you start/stop it? Y N

  When did it start?_____ How long does it last?_____
- What medications do you take? Please include over-the-counter drugs. *(copies of lists are acceptable)*

  _____

  _____

  _____

  _____
- Have you had problems with, been treated for, or are you currently being treated for any of the following (please include surgeries, injuries, or traumas):

	YES	NO		YES	NO		YES	NO
Ears	☐	☐	Stomach	☐	☐	Immune Deficiencies	☐	☐
Nose	☐	☐	Kidney/Bladder	☐	☐	Hepatitis	☐	☐
Throat	☐	☐	Skin	☐	☐	Tuberculosis	☐	☐
Neck/Thyroid	☐	☐	Diabetes	☐	☐	Eyes	☐	☐
Heart	☐	☐	Blood/Bleeding	☐	☐	Cancer	☐	☐
Lungs/Breathing	☐	☐	Neuro-Psych	☐	☐	Jaw/Teeth	☐	☐
Blood Pressure	☐	☐	Muscle/Joint	☐	☐			
Sinus	☐	☐	Allergies	☐	☐			