AUDIOLOGY SERVICES OF CHATTANOOGA, INC
CONFIDENTIAL PATIENT HISTORY

Patient Name:_____ Birthdate:_____

Address:_____

City:_____ State:_____ Zip:_____

MEDICAL HISTORY: Please Circle yes or no

Yes No Have you seen a doctor in the past six months? (Dr._____)
Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, give date_____
Yes No Have you ever had your hearing tested?
If yes, give date_____
Yes No Have you ever had any type of ear surgery?
If yes, type of surgery_____(Dr._____)
Yes No Do you take medicine every day?
For what condition?_____
Yes No Do you have any other medical conditions?
If yes, explain_____

ABOUR YOUR EARS Do you have any of these symptoms?
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 Which is your poorer ear? Same Right Left
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 ringing or buzzing in your ears?

ABOUT YOUR HEARING Do you experience difficulty with the following?
Yes No Understanding conversation
Yes No Hearing in a crowd
Yes No Hearing by telephone
Yes No How long have you had a hearing problem?_____
Yes No Does anyone else in your family have a hearing problem?
What relationship?_____
Yes No Do you now or have you ever worn a hearing aid?

SIGNATURE:_____ DATE:_____

AUDIOLOGY SERVICES
OF CHATTANOOGA, INC.

"We're here to help you hear."

Please list all medications and dosages you take daily below:

_____

_____

_____

_____

_____

_____

☐ Please mark box if you do not take daily medications.

Thank you,
Audiology Services of Chattanooga Staff

Patient signature_____

Date:_____