

Patient Case History Form

Please answer the following questions:

YES NO

- Any active drainage from the ear within the last 90 days?
 - Any history of sudden or rapidly progressive hearing loss within the last 90 days?
 - Have you experienced any acute (recent) or chronic long-term dizziness?
 - Is there a sudden or recent onset of unilateral (one ear) hearing loss within the last 90 days?
- Which is your best ear? Right Left Both the same
- Have you experienced any pain or discomfort in the ear?
 - Have you received any medical or surgical treatment for hearing loss?
 - Have you seen a physician regarding your ears? If so, who? _____
 - Have you had any ear surgery? If so, when? _____
 - Do you have allergies?
If so, please list: _____

 - What medications are you taking for any medical conditions?

 - Do you take a blood thinner?
 - Have you ever had a stroke or heart attack?
 - Have you ever had a trauma or blow to your head?
 - Have you ever been exposed to excessive noise?
 - Do you have any ringing, noises, or sounds in your ears?
 - Do you have any family members with hearing loss?
 - Have you ever worn a hearing aid before? If so, when?
 - Do you smoke?
 - May we have permission to send your results to your physician?



Family Audiology
ASSOCIATES

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ST. MARYS
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200 St. Clair St
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Medication Form

Name

Allergies

Do you take a blood thinner? Yes _____ No _____

Include all prescriptions and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginkgo). Include medications taken as needed (example: nitroglycerin).

Date	Name of Medication/Dose	Directions/Notes	Date Stopped

Use another sheet of paper, if needed.