Hearing Resource Center of San Mateo
100 S. Ellsworth Ave, Ste 303 & 711
San Mateo, CA 94401
(650) 579-4470
(650) 579-4471 fax

ADULT MEDICAL HISTORY

Date: _____

Name: _____DOB:_____ Age: _____

Please complete this form to the best of your ability so the Audiologist will better understand your health and concerns. If you are uncomfortable with any question, please do not answer it. Thank you.

REASON FOR VISIT: _______

OTOLOGIC HISTORY:

Please circle "Yes" if you have ever experienced any of the following symptoms. If so, please describe in the space provided.

N	Y	Have you ever been formally diagnosed with hearing loss? If so, when? Has it gotten worse?
N	Y	Are you experiencing any changes in your hearing (echo, tinny, muffled, etc) or finding it difficult to understand speech (in conversation, in a restaurant, on phone)? Please describe:
N	Y	Ringing, buzzing, whooshing or noises in your ears? If so, when did it start? Please describe:
N	Y	Vertigo or balance problems? If so, when did it start? Please describe:
N	Y	Fullness, pain or pressure in your ears? If so, when did it start? Please describe:
N	Y	Ear infections? If so, when was your last infection?
N	Y	Drainage from your ears? If so, when did it start?
N	Y	Ear surgery (including tubes)? If so, when? Please describe:
N	Y	Noise exposure in any setting (work, military, music, concert, hunting, etc.)? Please describe:
N	Y	Do you wear hearing aids? If so, when did you start?

FAMILY HISTORY:

Please circle "No" or "Yes" for question below. If "Yes", please describe in the space provided.

N	Y	Do you have family members of **<u>any</u>** age with hearing loss? Please describe:

MEDICAL HISTORY:
Please circle "Yes" if you have been diagnosed with any of the following conditions. If "Yes", please describe in the space provided.

N	Y	Autoimmune disorder? Please describe:	
N	Y	Cancer? Type:	Treatment:
N	Y	Diabetes? Type:	Treatment:
N	Y	Heart disease? Type:	Treatment:
N	Y	Head/neck injury? Please describe:	
N	Y	Hypertension or high blood pressure?	
N	Y	Kidney disease?	Treatment:
N	Y	Migraine/ headache?	Treatment:
N	Y	Stroke? When:	Effected side:

GENERAL HEALTH: Excellent Good Fair Poor

HEALTH CONDITIONS, SURGERIES, ETC (Please provide month/year): _____

_____

_____

ALLERGIES (Drugs, Environmental, Food): _____

MEDICATIONS: Please list all prescription and non-prescription drugs that you are currently taking and briefly describe what they are taken for or provide us a list.

_____/_____

_____/_____

_____/_____

_____/_____

_____/_____

HEALTH HISTORY:
Please circle "No" or "Yes" for the questions below. If "Yes", please describe.

N	Y	Caffeine intake? If yes, _____ cups/day
N	Y	Do you use tobacco? If yes, _____ packs/day
N	Y	Do you use alcohol? If yes, _____ drinks/day
N	Y	Do you suffer from lack of sleep?
N	Y	Do you suffer from increased stress or anxiety?