# Adult History Form



Patient Name__________________________________________ Birth Date ______________ Age ______

## Current Concerns (check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| **Hearing Loss** | Right Ear | Left Ear | Both Ears | None | Sudden Onset (Did this just occur?) |
| **Tinnitus** | Right Ear | Left Ear | Both Ears | None | |
| **Ear Pressure** | Right Ear | Left Ear | Both Ears | None | |
| **Ear Draining** | Right Ear | Left Ear | Both Ears | None | |
| **Dizziness** | Unsteadiness | Vertigo | Lightheaded | None | |

## Do You Wear Hearing Aids? (check all that apply)

Right Ear Left Ear Both Ears None

**Are they working properly?** Right Ear Left Ear Both Ears Neither

## Noise Exposure History (check all that apply)

Gunfire Airplanes Chainsaws Military Construction Jackhammers

Hunting Factory Work Power Tools Other:________________________________

## Have you **ever** had: (check all that apply)

| | | | |
|---|---|---|---|
| Chronic Earaches | Ear Surgery | Sudden Hearing Loss | Eye Surgery |
| Kidney Disease | Arthritis | Diabetes | Bleeding Problems |
| Osteoporosis | Hypertension | Dizziness | Family History of Hearing Loss |
| Meningitis | Head Trauma | Heart Disease | Allergies |

## Social History

| | | |
|---|---|---|
| Do you avoid social occasions because of hearing difficulty? | Yes | No |
| Do you find yourself having to ask people to repeat themselves? | Yes | No |
| Do you sometimes hear words but do not understand? | Yes | No |
| Do you have difficulty understanding in noisy places? | Yes | No |
| Have you been told that you speak loudly? | Yes | No |
| Do others complain the TV is too loud? | Yes | No |
| Are some voices easier to understand than others? | Yes | No |
| Do you find loud noises bothersome? | Yes | No |

What bothers you most about your hearing? ______________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## Please list all medications and supplements:

| Name | Dosage | Frequency | How Taken |
|---|---|---|---|
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I acknowledge by my signature below that I have been given the opportunity to review the Updated Notice of Privacy Practices for the office of Dr. Nanci Campbell. I have been informed that my personal information will **not** be shared with anyone without my permission.

Patient Name ___________________________________
Patient Signature ______________________________
Date signed ___________________________________

Guardian Signature _____________________________
Relationship ___________________________________
Date signed ___________________________________
Refused to sign_________________________________