EARS
Ear Associates & Rehabilitation Services Inc.

Name: _____ Age: _____ Date of Birth: _____

Occupation: _____

Reason for Today's Visit (Required):

_____

_____

Referring Doctor: _____ Phone #: _____
(Please, ONLY list if you have been evaluated by this doctor)

Family Doctor/Internist: _____ Phone #: _____

Other Doctor Involved in Your Care: _____ Phone #: _____

Drug Allergies: _____

_____

Ears	**Left**	**Right**	**Both**	**Began when?**
Hearing loss	_____	_____	_____	_____
Ear pain	_____	_____	_____	_____
Ear drainage	_____	_____	_____	_____
Ringing/noise	_____	_____	_____	_____
Hearing aid	_____	_____	_____	_____

Who is your hearing aid dispenser? _____

Noise Exposure

Military	Yes	No	Power tools	Yes	No
Hunting	Yes	No	Chain saws	Yes	No
Firing range	Yes	No	Snowmobiles	Yes	No
Trap shooting	Yes	No	Motorcycle	Yes	No
Small engines	Yes	No			

Occupational (describe): _____

Patient name: _____ Date of Birth: _____

Neurological			**Describe:**
Spinning	Yes	No	
Swimming sensation	Yes	No	
Loss of balance	Yes	No	
Veering to side	Yes	No	
Falls	Yes	No	
Lightheaded/giddy	Yes	No	
Fainting/blackouts	Yes	No	
Headaches	Yes	No	
Migraine history	Yes	No	
Previous head injury	Yes	No	
Difficulty with speech /swallowing	Yes	No	
Numbness/weakness of arms/legs	Yes	No	
Facial weakness	Yes	No	
Neck problems	Yes	No	
Jaw problems	Yes	No	

Previous Ear Surgeries:	Side	Year

Family History of Hearing Loss:	Parents	Siblings	Children

Past Medical History: Please list any prior major illnesses/injuries.

Patient name: _____ Date of Birth: _____

Current Medications:	Dose	Frequency

Other Surgeries:	Complications?	Year

Family Medical History:	Alive – Deceased	Age	Health Status or Cause of Death
Father			
Mother			
Sister/Brother			
Sister/Brother			
Sister/Brother			

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed

Do you have children? Yes No How many? _____

Do you live alone? Yes No Who lives with you? _____

How much caffeine do you drink per day? Coffee _____ Tea _____ Soda pop _____ Chocolate _____

How much salt do you eat? Low salt diet _____ No added salt _____ Regular intake _____

Do you smoke? Yes No Packs per day _____ E-cigarettes _____ Cigars _____

Do you smoke marijuana? Yes No How much?_____

Do you drink alcohol? Yes No Quantity _____

Do you take any street drugs? Yes No _____

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)? Yes No

If yes, please explain: _____

Patient name: _____ Date of Birth: _____

Eyes

Wear Glasses – Date of last exam: _____	Yes	No
Visual changes: _____	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No

Nose

Nasal congestion	Yes	No
Nasal drainage	Yes	No
Sinus problems	Yes	No
Environmental allergies	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid disease	Yes	No
Hormone problems	Yes	No
Fever	Yes	No
Weight loss/gain	Yes	No
Excessive fatigue	Yes	No

Date of last thyroid test: _____

Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Insomnia	Yes	No
Suicidal thoughts	Yes	No

Cardiovascular

Chest pain or angina	Yes	No
High blood pressure	Yes	No
Irregular pulse	Yes	No
Heart murmur	Yes	No
High cholesterol	Yes	No
Swelling in feet or hands	Yes	No
Leg pain while walking	Yes	No

Respiratory

Asthma	Yes	No
Bronchitis	Yes	No
Chronic cough	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	No

Gastrointestinal

Indigestion	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Liver disease/hepatitis	Yes	No
Abdominal pain	Yes	No
Change in bowel habits	Yes	No
Ulcers or gastritis	Yes	No

Genitourinary

Urinary tract infections	Yes	No
Painful urination	Yes	No
Blood in your urine	Yes	No
Incontinence	Yes	No
Difficulty voiding	Yes	No

The above information is accurate to the best of my knowledge.

_____ _____

Patient signature *Date*

I have reviewed the above information with the patient.

_____ _____

Physician name (printed) & signature *Date*