

Please fill out with black or blue ink ONLY. No pencil.

Health Questionnaire (please complete)

Patients Last Name	First Name	M.I.	HEC#													
Social Security#	<table border="1" style="border-collapse: collapse; width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>											Date	<table border="1" style="border-collapse: collapse; width: 100%; height: 20px;"> <tr> <td style="width: 33%;"></td> <td style="width: 33%;"></td> <td style="width: 33%;"></td> </tr> </table>			

A. Reason for visit

B. Medications

1. List all medications that you are taking. Include over the counter drugs.
 Name: _____ Strength: _____ Frequency: _____

2. Do you have allergies to medications? No Yes Don't know
 If yes, please list below:

C. Medical History

List all medical conditions and if appropriate, indicate the year and reason you were admitted to the hospital. Do not include normal pregnancies.

Year	Illness/Operation

D. Social

1. Do you smoke? No Yes _____ Packs per day
 2. Do you drink alcohol? No Yes _____ Glasses per day, week, month
 3. Do you drink caffeine products? No Yes _____ Cups per day, week, month

E. Family History

1. List all family members with a history of hearing loss or ear problems.

Relationship	Age	Type of hearing loss/ear problem

2. Please circle any of the following diseases which are common in your family, or have occurred in any family member. (This does not include family members by marriage or adoption).

- | | | | |
|------------------------|----------|---------------------|---------------------|
| Asthma | Diabetes | Migraine | Auto immune disease |
| Hay fever | Stroke | Bleeding disorder | Heart disease |
| Kidney disease | Cancer | High blood pressure | Tuberculosis |
| Surgical Complications | | | |

F. Symptom review. Please circle to indicate if you have had any of the following symptoms or diseases.

Neurological

- Stroke
- Migraine
- Blackout spells
- Weakness or paralysis
- Tremor/hand shaking
- Head injury
- Numbness/tingling sensations
- Muscle pains
- Significant arthritis
- Muscle irritation/tenderness

Head and Neck

- Dry Mouth
- Headaches
- Glaucoma
- Itching eyes or nose
- Hay fever
- Sneezing or runny nose
- Sinus trouble
- Dry eyes
- Eye disease
- Poor vision

Infections

- AIDS
- HIV positive
- Venereal disease
- Syphilis
- Gonorrhea
- Tuberculosis
- Chicken pox
- German measles
- Mumps

Endocrine

- Hormone therapy
- Thyroid
- Diabetes

Gastrointestinal

- Constipation
- Diarrhea
- Ulcer
- Heart burn
- Liver disease

Respiratory

- Pneumonia
- Tuberculosis
- Asthma
- Chronic cough
- Shortness of breath

Genital/Urinary

- Kidney disease
- Prostate problems
- Kidney stones
- Blood in urine

Emotional

- Nervous breakdown
- Depression
- Anxiety
- Chronic fatigue
- Suicidal tendencies

Cardiovascular

- Heart Attack
- Angina/chest pain
- Any heart trouble
- Heart murmur
- Arrhythmia
- High blood pressure
- Rheumatic fever

Blood/Lymphatic

- Bleeding disorder
- Anemia
- Previous transfusions
- Easy bruising

Gynecological

- Pregnancy
- Current breast feeding
- Vaginitis

Dermatologic

- Rashes
- Boils
- Eczema
- Psoriasis
- Sun sensitivity

General

- Cancer

Other

G. Ear Disease

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you ever had your hearing tested? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever been to a doctor for ear trouble? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you ever had ear surgery? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. have you ever worn hearing aids? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you wear hearing aids now? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you have blood relatives with hearing loss? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Today do you have any of the following (circle which) |
| | | Cold Allergies |
| | | Dizziness Ear infections |
| | | Ear Pressure Ear pain |
| | | Ear Drainage Ear drainage |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you bothered by ringing or noises in your ears? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you now taking more than a few aspirins a day? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you ever taken large doses of aspirin, Anacin, Bufferin, Emperin or Quinine How many? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever taken medications known to be damaging to your ears? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever received injections of any antibiotics of the Mycin family? Erythromycin? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you have ear drainage or pain? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Have you ever suffered a severe head injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had any of the following? (circle which) |
| | | Mumps Kidney infections |
| | | Diabetes Meningitis |
| | | Scarlet fever Measles |
| | | Ear Surgery Head injury |

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | Did you ever or do you now participate in (or use) any of the following? (answer each) |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Motorcycling |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Target shooting |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Hunting |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Snowmobiling |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Auto racing |
| <input type="checkbox"/> | <input type="checkbox"/> | 21. Power tools |
| <input type="checkbox"/> | <input type="checkbox"/> | 22. Musical instruments |
| <input type="checkbox"/> | <input type="checkbox"/> | 23. Private airplanes |
| <input type="checkbox"/> | <input type="checkbox"/> | 24. Any job that is noisy |
| <input type="checkbox"/> | <input type="checkbox"/> | 25. Farm equipment |
| <input type="checkbox"/> | <input type="checkbox"/> | 26. Chainsaws |
| <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you in the military service or national guard? What was your job? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you, in your job or hobbies, been exposed to loud noise levels? (machinery, gun fire, rock music, etc)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you wear hearing protection away from work? When did you start? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 30. Were you working around loud noise during the last 14 hours? |
| <input type="checkbox"/> | <input type="checkbox"/> | 31. Were you wearing hearing protection prior to this test today? |
| <input type="checkbox"/> | <input type="checkbox"/> | 32. Do you have trouble understanding speech in crowds, in church or at meetings? |
| <input type="checkbox"/> | <input type="checkbox"/> | 33. Do you understand speech less than you did 5 years ago? |
| <input type="checkbox"/> | <input type="checkbox"/> | 34. Do you have difficulty listening to music? |
| | | 35. How is your hearing today? |
| | | <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |