HEALTH HISTORY

Patient: _____

Hypertension	· Yes · No	Cholesterol	· Yes · No
Irregular Heart Beat	· Yes · No	Arthritis	· Yes · No
Angina or Heart Attack	· Yes · No	Dementia/Alzheimer's	· Yes · No
Sleep Apnea	· Yes · No	Cancer	· Yes · No
Heart/Congestive Heart Failure	· Yes · No	Diabetes	· Yes · No
Thyroid Disease	· Yes · No	Blood Transfusions	· Yes · No
Liver Disease/Hepatitis	· Yes · No	Stroke	· Yes · No
Kidney Disease	· Yes ·No	Immune Suppression or HIV	· Yes · No
Seizures	· Yes ·No	History of Bleeding Problems	· Yes · No
Psychiatric Problems/Depression	· Yes ·No	Tuberculosis or Herpes	· Yes · No

Do you have hearing loss?	· Yes · No	· Right · Left · Both
Do you have ringing in the ears?	· Yes · No	· Right · Left · Both
Do you have pain the ears?	· Yes · No	· Right · Left · Both
Do you or have you had drainage from the ear?	· Yes · No	· Right · Left · Both
Do you have ear fullness, plugging, or popping?	· Yes · No	· Right · Left · Both
Do you or have you had the frequent ear infections?	· Yes · No	· Right · Left · Both
Do you wear hearing aids?	· Yes · No	· Right · Left · Both
Have you ever had ear surgery?	· Yes · No	· Right · Left · Both

Has anyone in your family had ear surgery or early onset hearing loss? · Yes · No

Do you drink large amounts of coffee or tea? · Yes · No

Have you been exposed to loud noises (machinery, gunfire, music)? · Yes · No

Do you have dizziness or vertigo? (mark all that's appropriate) · Yes · No

- · Lightheadedness, "drunk-feeling"
- · Black out, fainting or loss of consciousness
- · Objects spinning around you
- · Swimming sensation in the head
- · You are spinning inside
- · Unsteadiness
- · Nausea
- · Tendency to fall
- · Rocking or floating
- · Vomiting

When did the dizziness first occur? _____

Is your dizziness constant or nearly constant? · Yes · No

Do you get a headache associated with your dizziness? · Yes · No

Does your dizziness occur in "attacks"? · Yes · No

How long do the attacks last? _____

Do you get dizzy from getting out of bed or up from a chair? · Yes · No

Do you take aspirin on a regular basis? · Yes · No

Do you take blood thinners? · Yes · No

What medications are you taking? _____

_____

Other Information: _____

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