Audiology Group
of Northern Colorado

PATIENT HISTORY SHEET

PATIENT NAME:______________________ DATE OF BIRTH:__________ TODAY'S DATE:__________

PRIMARY CARE PHYSICIAN OR REFERRING DOCTOR: ______________________________

CURRENT MEDICATIONS (INCLUDING VITAMINS AND SUPPLEMENTS):

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ENVIRONMENTAL/SEASONAL ALLERGIES

(INCLUDING LATEX, CONTACT ALLERGIES): **YES** **NONE (UNKNOWN)**

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PLEASE INDICATE ALL ILLNESSES AND HEALTH PROBLEMS FOR YOURSELF. (CHECK APPROPRIATE BOX)

	YES	NO
CANCER	☐	☐
ASTHMA	☐	☐
LUNG DISEASE/ COPD	☐	☐
DIABETES	☐	☐
HIGH BLOOD PRESSURE	☐	☐
RINGING IN THE EARS	☐	☐
HEARING LOSS	☐	☐
THYROID PROBLEMS	☐	☐
DIZZINESS	☐	☐
MIGRAINES	☐	☐
KIDNEY PROBLEMS	☐	☐
STROKE	☐	☐
NECK PROBLEMS	☐	☐
HEPATITIS TYPE:	☐	☐
UNUSUAL CHILDHOOD BEHAVIORS	☐	☐

DO YOU USE TOBACCO?

☐ **CURRENT** ☐ **FORMER** ☐ **NEVER**

DO YOU USE ASPIRIN?

☐ **CURRENT** ☐ **FORMER** ☐ **NEVER**