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)**:**

_____

_____

_____

_____

_____

ENVIRONMENTAL/SEASONAL ALLERGIES

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

_____

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

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

DO YOU USE TOBACCO? YES ☐ FORMER ☐ NO ☐

DO YOU USE ASPIRIN? YES ☐ FORMER ☐ NO ☐