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