AUDIO HISTORY

NAME_________________________________ EMPLOYER___________________________

AUDIO

Do you or have you ever had any of the following:

____Been to an ear specialist

____Frequent or severe ear infections

____Ringing or buzzing noise in ears

____Problems with balance or dizziness

____Scuba dived or piloted a plane

____ Difficulty hearing

____Noisy hobbies or activities – heavy equipment operation, chain sawing, loud music, etc.

____In the past have you taken any medications on a regular basis

____Do you wear hearing protection

____Sudden hearing loss

____Ear drainage, pain or pressure

____Ear surgery performed or recommended

____Exposed to gunfire or loud noises in the military

____Exposed to loud noise in past 14 hours

____ Had a head injury

____ None

COMMENTS:

Patient Signature_______________________________Date _________

(For Office use only)

AUDIO OBSERVATION	LEFT EAR		RIGHT EAR	
	Y	N	Y	N
Eardrum visible				
Eardrum normal				
Perforation				
Other abnormality				

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