ORANGE COUNTY PHYSICIANS' HEARING SERVICES

Name: _____ Age: _____ Date of Birth:_____

Birthplace: _____ Marital Status: Married Single Separated Divorced Widow

Occupation: _____ Previous Occupations:_____

Primary Care Doctor: _____ Date of Last Exam: _____

Other Physicians Caring For You_____

Are your symptoms a work related injury? Yes No Date of Injury_____

PAST MEDICAL HISTORY

Hypertension	Yes	No	Immune Supression or HIV	Yes	No
Irregular Heart Beat	Yes	No	Ulcers or Reflux (GERD)	Yes	No
Angina or Heart Attack	Yes	No	Asthma	Yes	No
Sleep Apnea	Yes	No	Cancer	Yes	No
Heart Failure/Congestive Heart Failure	Yes	No	Diabetes	Yes	No
Thyroid Disease	Yes	No	Blood Transfusions	Yes	No
Liver Disease/Hepatitus	Yes	No	Bleeding Problems	Yes	No
Kidney Disease	Yes	No	Family History of Bleeding Problems	Yes	No
Seizures	Yes	No	Previous History of Bleeding Problems	Yes	No
Psychiatric Problems	Yes	No	Tuberculosis or Herpes	Yes	No

Do you take blood thinners? Yes No

Do you take aspirin containing medications? Yes No

PLEASE DESCRIBE YOUR SYMPTOMS OF YOUR PRESENT PROBLEM

_____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

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 frequently take Aspirin?	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?	Yes	No			

If yes, please circle the symptom(s) that describe your dizziness most accurately:

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

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?_____

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