Suncoast Audiology, LLC

Date:_______________

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name:	
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Previous or referring doctor:	

	PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Recurrent Ear Infections ☐ Rheumatic Fever
Illnesses past OR present:	☐Shingles
	☐ Ear tumor
	☐ Brain tumor
	List any significant medical problems that other doctors have diagnosed

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (including aspirin)

Name the Drug	**Strength**	**Frequency Taken**

Alcohol/ Caffeine	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
	Recovering alcoholic/drug addict?	☐ Yes	☐ No
	Do your ears ever ring when you drink?	☐ Yes	☐ No
	Do you drink caffeine?	☐ Yes	☐ No
	How many cups/day?	☐ Yes	☐ No
	Do you use artificial sweetener or drink diet drinks?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you use CBD oil (not medical marijuana)?	☐ Yes	☐ No

OTOLOGIC (HEARING) HISTORY

Do you have a history of hearing loss?	☐ Yes	☐ No
Do you use hearing aids? How long?	☐ Yes	☐ No
Do you experience dizziness? If so, have you been evaluated for it?	☐ Yes	☐ No
Do you experience tinnitus (ringing, buzzing, whooshing, etc.)?	☐ Yes	☐ No
Do you know what caused your ear issue?	☐ Yes	☐ No
Is your tolerance to LOUDER sounds the same as those around you?	☐ Yes	☐ No
Is your tolerance to SPECIFIC sounds the same as those around you?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Do you use hearing protection in noise?	☐ Yes	☐ No

SOUND HISTORY

DO YOU HAVE A HISTORY OF:	☐ Yes	☐ No
Noise exposure?	☐ Yes	☐ No
Head trauma?	☐ Yes	☐ No
Explosive injury to the ears?	☐ Yes	☐ No
Intravenous antibiotics? (If yes, please list):	☐ Yes	☐ No
Ear infection?	☐ Yes	☐ No
Gun usage?	☐ Yes	☐ No
Family history of hearing loss?	☐ Yes	☐ No
Occupational/work related/recreational noise exposure?	☐ Yes	☐ No