

Name: _____

DOB: _____

Health Assessment

EAR HISTORY:

- | | | |
|--|--|---|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Drainage | <input type="checkbox"/> Tolerance problems |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Headaches | <input type="checkbox"/> Head trauma |
| <input type="checkbox"/> Vertigo/dizziness | <input type="checkbox"/> Family hearing loss | <input type="checkbox"/> Ototoxic |
| <input type="checkbox"/> Noise exposure | <input type="checkbox"/> Tinnitus/head noise | |

MEDICAL HISTORY:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rubella | <input type="checkbox"/> Upper respiratory infections |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Colds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Fevers | <input type="checkbox"/> Seizures |

CHILDREN AND YOUNG ADULTS:

- | | | |
|---|---|--|
| <input type="checkbox"/> Prematurity | <input type="checkbox"/> RDS | <input type="checkbox"/> Developmental delay |
| <input type="checkbox"/> Low birth weight | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Speech/language delay |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> ABO/RH incompatibility | <input type="checkbox"/> Other |

Medications: _____

Surgeries: _____

Hearing Aid Usage: _____

Additional History: _____