Assured Audiology & Hearing Solutions

MEDICAL HISTORY

What is your primary reason for your visit today? _____

_____

How is your general health? _____

Please list any recent surgeries or hospitalizations (If more space is needed, please continue to the right)

Surgeries/Hospitalizations	Year
_____	_____
_____	_____
_____	_____
_____	_____

Please Check if you have experienced any of the following:

☐ Allergies	☐ Dementia	☐ Kidney Problems	☐ Parkinson's
☐ Arthritis	☐ Depression/Anxiety	☐ Measles	☐ Seizures
☐ Asthma	☐ Diabetes	☐ Meningitis	☐ Stroke/TIA
☐ Bell's Palsy	☐ Heart Disease	☐ Migraines	☐ Vascular Problems
☐ Blood Disorder	☐ Hepatitis	☐ Multiple Sclerosis	☐ Vision Problems
☐ Cancer	☐ High Blood Pressure	☐ Mumps	
☐ Concussion	☐ HIV/Aids or Other	☐ Pacemaker	

Please list any other conditions experienced if not listed above _____

_____

_____

Please list all medications you are currently taking :

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

* If you have a list of medications, we will be glad to make a copy for our records*

Signature _____ Date _____