



Lake Jackson
Ear, Nose and Throat

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**Please complete this health history form. It helps your audiologist best determine treatment and possible fitting of hearing devices.*

Today's Date

Patient Name

Date of Birth/Age

Occupation

Marital Status

Referred By

Primary Doctor

Past/Current Medical Problems: _____

Implanted Devices: _____

Current Medications (and reason for taking): _____

Allergies to Medications, Environmental or Dermatology: _____

Family Medical Problems: *(please fill in which family member: Mother, Father, Grandparents, Brother, Sister)*

Hearing Problems: _____

Ear/Nose/Throat Problems: _____

Bleeding/Clotting Problems: _____

Diabetes: _____

Cancer: _____

Hematology: _____

Neurological: _____

Other: _____