



**Ears / Eyes:**

	No	Right	Left
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuating Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus (ringing, buzzing, other noises)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perforated / Torn Eardrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Eye Patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DATE:

NAME:

DOB:

**Headache History:**

	No	Yes		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		
How often do they occur		<input type="checkbox"/> daily	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly
How long do they last		<input type="checkbox"/> minutes	<input type="checkbox"/> hours	<input type="checkbox"/> days
Headache medications	<input type="checkbox"/>	<input type="checkbox"/> <b>List:</b>	_____	
Headache medications are taken		<input type="checkbox"/> daily	<input type="checkbox"/> as needed	
Migraine Diagnosis	<input type="checkbox"/>	<input type="checkbox"/> <b>By:</b>	_____ <b>When:</b>	
With nausea vomiting	<input type="checkbox"/>	<input type="checkbox"/>		
Caused by certain food / drink	<input type="checkbox"/>	<input type="checkbox"/>		
Family history of migraine	<input type="checkbox"/>	<input type="checkbox"/>		
Related to menstrual cycle	<input type="checkbox"/>	<input type="checkbox"/>		

**Habits:**

	No	Yes
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>
Recreations Drugs	<input type="checkbox"/>	<input type="checkbox"/>

**Family History:**

	No	Yes
Do you live alone	<input type="checkbox"/>	<input type="checkbox"/>
Family history of dizziness	<input type="checkbox"/>	<input type="checkbox"/>

**Past Medical History:** Please describe and list dates.

Hospitalizations or Surgery:

Motor Vehicle Accident:

Head Injury:

Chronic illness (e.g. diabetes, hypertension) requiring medication:

Intravenous antibiotics, chemotherapy, radiation therapy:

**Medications:** Please list

**Division of Audiology**

<http://pennhealth.com/ent/services/audiology.html>

Appointments:

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