Audiology and Hearing Aid Center
Cynthia Olsen, MCD, CCC-A
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Clinical Audiologists
1740 N. Milwaukee
Boise, ID 83704
208-658-0238

Name______________________________ Date________ Dr. Reviewed_____________

Medical History

Please provide the following information:

Current Illness
In your own words, what is the specific reason for your visit?______________________________
____
Date of Injury or Onset of Symptoms____
Date of Last: Physical Examination______________________ Aspirin Use______________________

Past Medical History

Environmental Allergies____
____
Current Medications (please give dosage)______________________________________
____
Medical Illnesses (such as high blood pressure)__________________________________
____
Previous Surgeries (please list with dates)______________________________________
____

Review of Personal Health Systems

(please check any of the following conditions you have or are experiencing repeated symptoms)

___Heart disease
___Muscle/Bone/Joint Problems
___Nasal Obstruction to Breathing
___High Blood Pressure
___Hepatitis
___Asthma/Shortness of Breath
___Heartburn/Reflux/Ulcers
___Cancer
___Hearing Loss/Ear Disease
___Difficulty swallowing
___Easy Bruising
___Thyroid/Endocrine Problems
___Snoring/ Sleep Apnea
___Eye Problems
___Problems with anesthesia
___Diabetes
___Kidney Disease
___Bleeding Disorders

Family History (please check any of the following conditions that prevail in your family)

___Heart Disease
___Bleeding Disorders
___Problems with Anesthesia
___High Blood Pressure
___Cancer
___Diabetes
___Hearing Loss

Tobacco Use ◻ Never ◻ Occasionally ◻ Regularly
_____ Packs/Day for _____ Years

Alcohol Use ◻ Never ◻ Occasionally ◻ Regularly ◻ Excessive