Date: ______________________

Scarlet M. Aviles, Au.D.

Patient Medical History

Name: ______________________ Birthdate: ______________________

Check any past/current problems:

- ☐ Arthritis
- ☐ Asthma/Allergies/Sinus
- ☐ Cancer ______________
- ☐ Chemotherapy
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug dependency
- ☐ Frequent ear infections
- ☐ Heart problems
  Describe: ______________
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Nervous problems
- ☐ Psychiatric problems
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Venereal disease

Other: ______________________

Previous Surgeries: ______________________

Current or Past Occupation(s): ______________________

Smoker? ☐ Yes ☐ No If you quit, when? ________ How much? ________ How long? ________

Alcoholic beverages? ☐ Yes ☐ No How many, how often? ______________

Caffeinated beverages? ☐ Yes ☐ No How many, how often? ______________

Please list all medications and supplements ☐ No medications ☐ See List

Family History

Have you had a family member with any of the following? If so, please state family member.

Hearing loss / Dizziness ______________________

Diabetes ______________________

Kidney disease ______________________

High blood pressure ______________________

Dementia ______________________

Migraines ______________________