William B. Cobb, M.D., P.A.
Ewen Y. Tseng, M.D., P.A.

Keith E. Matheny, M.D.

ADULT EAR HISTORY

Name: _____ Date: _____

Please answer the questions carefully. CIRCLE THE ANSWER AND PRINT LEGIBLY.

1. Why are you here to see the doctor: _____
2. Do you have EAR PAIN? . . . . . Yes No
   How long has it been present? _____ days _____weeks_____months_____ years
   Severity: Mild Moderate Severe
   Location: Left Right Both ears
   Frequency of Attacks: _____ x a day _____x a week _____ x a month
   Duration of Attacks: _____minutes _____hours _____days
   What makes it worse?
   Pulling on outer ear Other: _____
   Chewing
   Getting water in the ear
   Loud sound coming into ear
3. Do you have EAR DRAINAGE? (other than wax) . . . . . Yes No
   How long has it been present? _____ days _____ weeks _____ months _____ years
   Location: Left Right Both ears
   Amount of drainage: Slight Moderate Large
   Duration of drainage: Continual Intermittent
   Character: Clear White Yellow Bloody
   When did it last occur?
4. Do you have a STOPPED UP OR PRESSURE FEELING in your ears? . . . . . Yes No
   How long has it been present? _____ days _____ weeks _____ months _____ years
   Location: Left Right Both ears
   Duration: Continual Intermittent
5. Do you hear a NOISE in your ear? . . . . . Yes No
   How long has it been present? _____ days _____ weeks _____ months _____ years
   Location: Left Right Both ears
   Duration: Continual Intermittent
   Character: Ringing, Roaring, Snapping, Popping, Hissing, Other: _____
   What do you think caused it? _____
   Have you ever taken large doses of Aspirin, Anacin, Bufferin, Empirin or Quinine? . . . . . Yes No
6. Do you have a HEARING LOSS? . . . . . Yes No
   How long has it been present? _____ days _____ weeks _____ months _____ years
   Duration: Continual Fluctuating Intermittent
   Location: Left Right Both ears
   Onset: Sudden Gradual
   What do you think caused it? Congenital, Hereditary, Noise exposure, Injury, Medication, Hole in eardrum,
   Other: _____
   Has your hearing ever been tested? Yes No When? _____
   How has your hearing loss been treated?
   Medically _____ by whom? _____
   Surgically _____ by whom? _____
   Hearing aid _____ by whom? _____
   Do any blood related family members have a hearing loss? . . . . . Yes No
7. Did you have FREQUENT CHILDHOOD INFECTIONS? . . . . . Yes No
   How were they treated?
   Medically - antibiotic
   allergy treatment
   Surgically - lancing of eardrum
   tubes
   adenoids & tubes
   tonsillectomy & adenoidectomy & tubes
   radiation of eustachian tubes
   other
   Did you have any complications resulting from childhood ear infections: skin cyst in ear, mastoid infection, hole in eardrum, hearing loss, meningitis, brain abscess? . . . . . Yes No
8. Have you had an INJURY to your ears? . . . . . Yes No
   If yes, describe: _____
9. Do you have DIZZY SPELLS? . . . . . Yes No
   If yes, ask nurse for additional dizziness questionnaire
10. Have you had any of the following diseases? When (circle and date)

Red measles	Diphtheria	Pneumonia	Lung disease
German measles	Heart murmur	Arthritis	Meningitis
Mumps	Heart attack	Polo	Encephalitis
Chicken pox	Stroke	High blood pressure	Malaria
Asthma	Diabetes	Ulcer or stomach disease	Tuberculosis
Scarlet fever	Cancer	Nerve or psychiatric illness	Syphilis
Rheumatic fever	Seizures	Bleeding disorder	Yellow jaundice
Thyroid disease			

11. Have you ever had any surgery? Yes No When, what for? _____
12. Any other hospitalizations? _____
13. Are you presently taking any medications?
14. Are you allergic to Penicillin? Yes No Any other medicine? _____
15. Do you smoke? . . . . . Yes No
16. If the following are deceased, of what did they die?
    Mother _____ Sister(s) _____
    Father _____ Brother(s) _____