MEDICAL HISTORY FORM

Name: _____ Date:_____

DOB: _____

Medical Conditions:

(Check all that apply)

- ○ Infectious Disease
- ○ Heart Problems
- ○ Diabetes
- ○ Head Injury
- ○ Cancer
- ○ Headache
- ○ High Blood Pressure
- ○ Kidney Failure
- ○ Stroke

Other (please explain):

_____

_____

General Health Questions:

1. Do you currently wear corrective lenses for vision problems? Yes____ No ____
2. Have you noticed less interest in hobbies and other fun activities in the past 6 months? Yes____ No ____
3. Have you noticed trouble remembering appointments in the past 6 months? Yes____ No ____
4. Have you had any issues or problems with daily thinking and/or memory in the past 6 months? Yes____ No ____
5. Do you notice ringing, buzzing, or hissing in your ears or head? Yes____ No ____
6. Because of the ringing, do you have trouble falling asleep at night? Yes____ No ____
7. Do you feel irritable or depressed because of the ringing? Yes____ No ____
8. Do you ever lose your balance or feel dizzy? Yes____ No ____
9. Does moving your head quickly make you feel dizzy or cause you to feel nauseous? Yes____ No ____
10. Do you fear falling? Yes____ No ____