Specialty Care- Audiology
Lorrie Roberts, Au. D., CCC-A

Date: _____

Patient Name (First, Last & M.I.): _____

D.O.B. _____ Age: _____

If the patient is under the age of 18, please fill in A & B.

A) Legal Guardian's First & Last Name: _____
B) Relationship to patient: _____

Referring Physician(s): _____

Pharmacy (Name & Location): _____

Reason for today's visit: _____

Patient Social History

Are you employed? _____ Occupation? _____

Marital Status: S M W D

Do you smoke? ☐ Yes ☐ No If yes, how many? _____ How long? _____

Do you have any of the following symptoms? If so, please circle:

Headache	Nosebleed	Ear Fullness/Pressure
Nasal Congestion	Loss of smell/taste	Difficulty Swallowing
Facial Pain	Hearing Loss	Cough
Nasal Discharge	Ringing in Ears	Hoarseness
Postnasal Drip	Ear Drainage	Neck Mass/Swollen Gland
Frequent sneezing	Dizziness/off balance	Snoring

Please complete the backside of this sheet. Thank you. →

Past Medical History (if not applicable, specify "N/A" under pertaining sections).

Present Medications: _____

_____

_____

What medications are you allergic to? _____

What other allergies do you have? _____

_____

Recent Labs/Radiology Studies: When & Where? _____

_____

_____

Major Illnesses or Surgeries: _____

_____

_____

_____

DO NOT WRITE BELOW THIS LINE

Weight: _____ B/P: _____

Height: _____ Temp: _____

Notes: _____

_____

_____

_____