CAPE COD HEARING CENTER -- ADULT CASE HISTORY & PROFILE

Please indicate if you take medications for any of the following:

☐ Diabetes	☐ Blood Pressure	☐ Diuretics
☐ Pain	☐ Inflammation	☐ Anxiety
☐ Neurologic Disease	☐ Antibiotics	☐ Blood Thinners
☐ Thyroid	☐ Cancer	☐ Cholesterol
☐ Vertigo	☐ Depression	

Please check any of the following that you currently have or have had in the past:

☐ Arthritis	☐ Pacemaker	☐ Parkinson's
☐ Ear Infections	☐ High Blood Pressure	☐ Scarlet Fever
☐ Bell's Palsy	☐ High Cholesterol	☐ Diabetes: Type 1 or Type 2
☐ HIV	☐ Stroke / TIA	☐ Thyroid
☐ Malaria	☐ Head Injury	☐ Other: Please Specify
☐ Hepatitis	☐ Measles/Mumps	_____
☐ Cardio-Vascular Disease	☐ Menengitis	_____
☐ Pacemaker	☐ Migraines	_____

How much do you consume of the following:

Caffine/Day _____ Nicotine /Day _____ Alcoholic Drinks per Day / Week _____

Medication List:

Medication Name	Dosage	Administered (Circle One)
		Oral / Topical / Injection / IV
		Oral / Topical / Injection / IV
		Oral / Topical / Injection / IV
		Oral / Topical / Injection / IV
		Oral / Topical / Injection / IV
		Oral / Topical / Injection / IV
		Oral / Topical / Injection / IV
		Oral / Topical / Injection / IV