INTAKE FORM - EARS

Name: _____ DOB (dd/mm/yyyy): _____

What main ear issue prompted your referral to Dr. Mabini? (please circle):

Ear pressure Ear pain Recurrent ear infections Tinnitus (ringing in ears) Hearing loss

Other: _____

Do you have, or have you had any of the following symptoms? (please check if yes):

- ☐ Recurrent ear infections
- ☐ Ear pain/pressure
- ☐ Drainage from ears
- ☐ Fevers
- ☐ Irritability
- ☐ Swollen/sore lymph nodes
- ☐ Trouble concentrating
- ☐ Asking people to repeat themselves often
- ☐ Trouble hearing with background noise
- ☐ Previous ear tubes
- ☐ Turning TV volume up higher than normal
- ☐ Not responding when spoken to
- ☐ Poor school performance
- ☐ Balance problems
- ☐ Speech delay, or muffled speech (in children)

Have you had recurrent ear infections? If yes, please state how many episodes over what duration of time (e.g. three infections in the last year and a half): _____

Have you been treated with antibiotics for each infection? Which antibiotics?:

_____

Do you wear hearing aids? If yes, in both ears or just one? How often do you wear them?:

_____

Do you, or have you used a nasal steroid spray (e.g. Nasonex, Avamys, Omnaris, etc.)? If yes, how long did you consistently use it for (i.e. on a daily basis)?:

_____

Do you have a history of excessive noise exposure (e.g. occupational)?:

_____

Has anyone in your family had hearing loss at an early age (before age 40)?: _____

Have you ever been admitted to the hospital and treated for a serious infection of any kind?:

_____