

# Ear History & Exam

Chief Complaint:

Date:

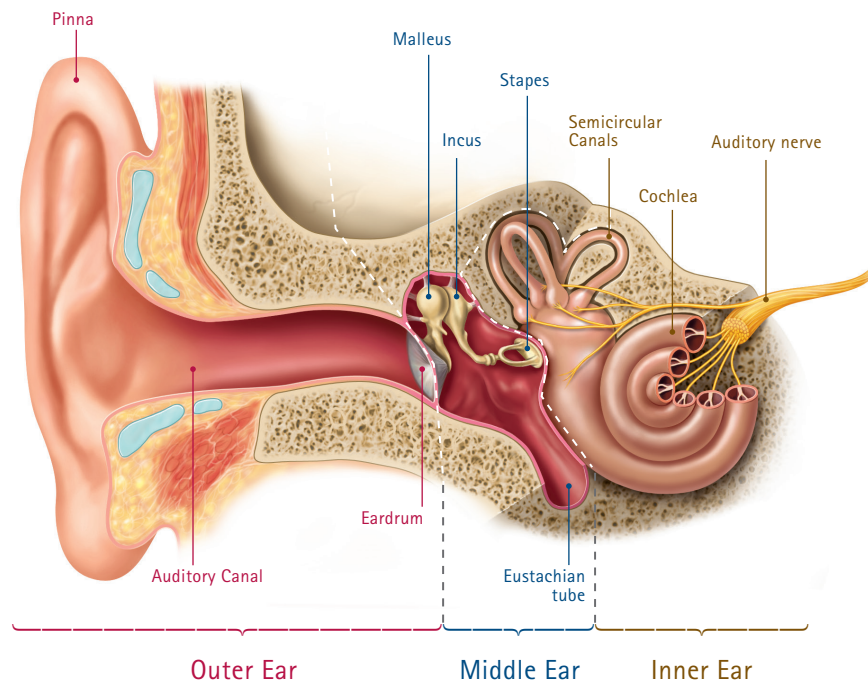
Referring Physician:

Insurance:

History (describe or complete checklist as yes or no):

- Hearing Loss (SNHL, Mixed, Conductive):  Yes  No
- Tinnitus:  Yes  No
- Vertigo:  Yes  No
- VII Cranial Nerve:  Yes  No
- TMJ/ Ear Pain:  Yes  No
- Skin Quality:  Yes  No
- Central Nervous System:  Yes  No
- Immune System:  Yes  No
- General Health:  Yes  No
- Motivation:  Yes  No

Exam (circle or describe):



Assessment:

Plan: