NORTH SIDE
AUDIOLOGY GROUP, INC.

NORTH SIDE AUDIOLOGY GROUP

MEDICATION HISTORY

Medication Name	Dose	Times per day	Why do you take it?

HEALTH HISTORY

INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

DIABETES	EAR FULLNESS	RADIATION
THYROID DISEASE	EAR ITCHINESS	DIZZINESS
ALLERGY/SINUS ISSUES	EAR PAIN	SMOKING
EAR DRAINAGE	HEART DISEASE	HIGH BLOOD PRESSURE
HIGH CHOLESTEROL	BLOOD THINNERS	

OTHER HEALTH ISSUE _____

The above information is true and complete to the best of my knowledge. Additionally, I am aware of this office's Notice's of Privacy Practices and fully understand my privacy rights as a patient of the North Side Audiology Group.

_____ _____

Signature Date