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KATHI BALETSTINO-ESTS, Au.D.
AUDIOLOGY
HEARING SERVICES
AUDIOVESTIBULAR TESTING

Patient Name: _____ **DOB:** _____ **Sex:** M___ F___

Home Address: _____

City_____ **State** _____ **Zip Code** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone**_____

E-mail address: _____

Race (circle one): American Indian or Alaska Native Asian White Hispanic

African American Native Hawaiian or other Pacific Other

Language: _____

Primary Care Physician: _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Street: _____**City:** _____

Reason for visit _____

List all medications you are currently taking:_____

_____

_____

_____

_____

Do you have any allergies to medications? No___ Yes___ If yes, to what?_____

List any previous surgeries with dates:_____

_____

Are you pregnant? Yes ___ No ___ **Are you breastfeeding?** Yes___ No___

Signature of Patient/Guardian _____**Date:** _____