MID SOUTH
HEARING AID CENTER

301 Florence Avenue
Statesboro, GA 30458
(912) 489-6422

2066 Watson Blvd • Suite 406
Warner Robins, GA 31093
(478) 599-9992

1905 B North Columbia St.
Milledgeville, GA 31061
(478) 599-9992

3321 Northside Drive
Macon, GA 31201
(478) 599-9992

Mid South Hearing Aid Center Patient Health History Form

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item.

PATIENT'S LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: ____

DATE OF BIRTH: _____ AGE: _____ RACE: _____ SEX: _____

NAME OF PRIMARY CARE PHYSICIAN: _____

PHARMACY PREFERENCE (INCLUDE LOCATION): _____

REASON FOR TODAY'S VIST: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION(S)?: ____ YES ____ NO

If yes, please list below:

Name of Medication	Type of Reaction

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