Patient History Form

Patient Name: _____ **Date:** _____

1. Chief complaint: □ Hearing Loss (□ Right ear / □ Left ear) □ Tinnitus/Ringing □ Dizziness
□ Difficulty hearing (□ in Quiet □ in Noise) □ Telephone (□ Right ear □ Left ear)

2. How long have you noticed this difficulty? _____

3. Is this problem due to a work-related injury/exposure? □Yes □ No
If so: Date of Injury: _____ Explain: _____

4. Do you feel your hearing is changing? □Yes □ No (□ Gradual □ Sudden)

5. Have you ever been exposed to loud noise, either recently or in the past? □Yes □ No
If so, please mark all that apply:
□ Farm Machinery □ Music □ Hunting/Shooting □ Factory Noise
□ Power Tools □ Military □ Jet Engines □ Other: _____

6. Have you seen an Ear, Nose and Throat Physician? □Yes □ No
If so, who did you see? _____When? _____

7. Have you ever had surgery that may have affected your hearing? □ Yes □ No

8. Is there a history of hearing loss in your family? □Yes □ No If so, who? _____

9. Have you ever had an ear infection? □Yes □ No (If yes, □ as a child □ as an adult)

10. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?
□ Yes □ No If yes, please describe: _____

11. Do you take any prescription medications on a regular basis? Please list:
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____

12. Please check any of the following that you currently have or have had in the past:

□ Arthritis	□ HIV	□ Malaria	
□ Asthma	□ Head Injury	□ Measles	□ Parkinson's
□ Bell's Palsy	□ Heart Trouble	□ Meningitis	□ Sinusitis
□ Cancer	□ Hepatitis	□ Mumps	□ Stroke/TIA
□ Diabetes	□ High Blood Pressure	□ Neurological Symptoms	□ Visual Trouble-Loss/Sight

13. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
_____ Improved hearing in quiet _____ Improved hearing in noise
_____ Cosmetic appearance _____ Expense

14. If you are currently using a hearing aid, or have in the past, please answer the following:
Which ear is/was aided? □ Right □ Left
How long have you used a hearing aid? _____
What would improve your current hearing aid? _____