Patient History

Patient Name: _____ Date of Visit:_____

Please **circle** the appropriate response for your history and describe as indicated.

1. Do you have difficulty hearing or understanding? No Yes
   If yes, is one ear worse than the other? No Yes (Right / Left / Both)
   Was the onset: gradual sudden

2. Have you had a hearing test before? No Yes, when _____

3. Do you have ringing in your ear(s)? No Yes (Right / Left / Both)

4. Do you have a history of ear infections? No Yes

5. Have you noticed any pain, pressure or fullness in your ear(s)? No Yes (Right / Left / Both)

6. Do you experience dizziness? No Yes (please describe) _____
   _____

7. Do you have a history of noise exposure? No Yes, when _____

8. Have you ever had ear surgery? No Yes, when _____

9. Have you ever had a head or ear injury? No Yes, please describe _____
   _____

10. Does any member of your family have a hearing loss? No Yes, who _____
    _____

11. Have you ever worn hearing aids before? No Yes (Right / Left / Both)
    If yes, how long have you worn devices? _____ Months/_____Years

12. Have you ever taken chemotherapy medications? No Yes

13. Are you currently enrolled in hospice? No Yes
    If yes, is this visit related to your hospice condition? No Yes

14. Please list any other medical conditions you are currently being treated by a physician for _____
    _____

Patient Signature _____ Audiologist Initials _____