# ADULT MEDICAL HISTORY

1. Chief complaint: ☐Hearing Loss ( ☐Left Ear/☐Right Ear ) ☐Tinnitus/Ringing ☐Dizziness
   ☐Difficulty Hearing ( ☐In Quiet ☐In Noise ☐Telephone--☐Right Ear ☐Left Ear )
2. Have you ever had your hearing tested? ☐Yes ☐No
   If yes, please give date: _____ By Whom? _____
3. Have you ever had surgery that may have affected your hearing? ☐Yes ☐No
   If yes, what type? _____ By Whom? _____
4. Have you seen an Ear, Nose and Throat Physician (ENT)? ☐Yes ☐No
   If so, who did you see? _____When? _____
5. Have you ever had an ear infection? ☐Yes ☐No ( If yes, ☐as a child ☐as an adult )
6. Have you ever had a serious illness that may affect your hearing? (i.e., Scarlet Fever, Meningitis, Mumps, etc.)
7. Do you take medications every day? ☐Yes ☐No
   **Please supply list of multiple medications if needed.
   Briefly describe for what condition?
   _____
8. Do you take **Aspirin** or any **blood thinner's**? ☐Yes ☐No
   (If yes, name of medication _____, How often do you take it? _____)
9. Do you have any other medical conditions that may affect your hearing? ☐Yes ☐No
   If yes, please briefly explain:
   _____
10. Is there a history of hearing loss in your family? ☐Yes ☐No
    If so, who? _____
11. Please check any of the following that you currently Have or have had in the past:

| | | | |
|---|---|---|---|
| ☐Arthritis | ☐Heart Trouble | ☐Measles | ☐Parkinson's |
| ☐Asthma | ☐Hepatitis | ☐Meningitis | ☐Bell's Palsy |
| ☐High Blood Pleasure | ☐Sinusitis | ☐Diabetes | ☐Visual Trouble-Loss/Sight |
| ☐Neurological Symptoms | ☐Head Injury | ☐HIV | |

    ☐Cancer (please mark if any treatment)—Radiation Y/N, Chemotherapy Y/N, Other _____
    Type of Cancer _____
12. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?
    ☐Yes ☐No If yes, please describe: _____
13. Have you seen a doctor for wax removal? ☐Yes ☐No
14. Do you have drainage of the ear? ☐Yes ☐No
15. Are you experiencing pain in your ear? ☐Yes ☐No

**About Your Hearing:**

16. Do you think your hearing is changing? ☐Yes ☐No ( ☐Gradual ☐Sudden)
17. Is this problem due to a work-related injury/exposure? ☐ Yes ☐No
18. How long have you had difficulty in communicating? _____
19. Have you ever been exposed to loud noise, either recently or in the past? (i.e., farm equipment, power tools, lawn mowers, chain saws, fire arms, military, etc.) ☐Yes ☐No
    If yes, was hearing protection used? ☐Yes ☐No or ☐Sometimes
20. Do you now or have ever worn hearing aids? ☐Yes ☐No

    Which ear is/was aided? ☐Right ☐Left
    Type of hearing aid? _____
    How long have you used a hearing aid? _____
    What would improve your current hearing aid? _____
21. Please rank the following in order of importance ( 1-4 ), if a hearing aid is recommended for you:
    ____Improve hearing in quiet environments ____Improve hearing in noisy environments
    ____Cosmetic appearance ____Expense