Patient name: ______________________________
Preferred first name: ______________________________
Birthdate: ____________________ Date: ____________________

Home Living Situation (mark all that apply)
☐Alone ☐with Spouse ☐with Children
☐with Parent(s) ☐in Assisted Living
☐in Nursing Home ☐Other

Do you currently use tobacco products? ☐Yes ☐No
☐Cigarettes ☐Cigars ☐Pipe ☐Smokeless

Do you use a walker, wheelchair or cane?
☐None ☐Walker ☐Wheelchair ☐Cane

Do you use oxygen? ☐Yes ☐No

Do you wear corrective lenses? ☐Yes ☐No
☐Contacts ☐Glasses ☐Both

Have you ever received treatments with intravenous antibiotics or chemotherapy? ☐Yes ☐No

Allergies? (To include but not be limited to: Food, Medications, etc.)
____

HAVE YOU EXPERIENED ANY OF THE FOLLOWING?

☐AIDS/HIV	☐Ear Infections
☐Arthritis	☐Ear Surgeries
☐Blood Disorders	☐Genetic Disorders
☐Cancer	☐Glaucoma
☐Chicken Pox/Shingles	☐Headaches/Migraines
☐Depression	☐Head/Neck Injury
☐Dementia/Alzheimer's	☐Mumps
☐Heart Problems	☐Scarlet Fever
☐High Blood Pressure	☐Stroke
☐Macular Degeneration	☐TMJ
☐Measles	☐Thyroid Disease
☐Meningitis	☐Vascular Problems
☐Diabetes	☐Other____________

☐Cerumen/Ear Wax Buildup	☐Right	☐Left
☐Ear Drainage	☐Right	☐Left
☐Ear Pressure/Fullness	☐Right	☐Left
☐Sensitivity to Loud Sounds	☐Right	☐Left
☐Ear Deformity	☐Right	☐Left
☐Ear Pain	☐Right	☐Left
☐Itchy Ears	☐Right	☐Left

TINNITUS/RINGING/BUZZING

☐Tinnitus/Ringing/Buzzing in the ears
☐Right ☐Left
☐Constant ☐Intermittent
When did it start? ______________________________
What does it sound like? ______________________________

Has your hearing been previously tested? ☐Yes ☐No
If yes, please list when, if known: ____________________

Do you have a Family History of Hearing Loss?
☐Yes ☐No

Do you have a History of Noise Exposure? ☐Yes ☐No
If yes, environments: ______________________________
Did you wear hearing protection? ☐Yes ☐No
Have you ever used firearms/guns? ☐Yes ☐No

Why have you decided to have your hearing tested today? ______________________________

When did you first notice a problem with your hearing?
☐Sudden Onset ☐Months Ago ☐Years Ago

Do you wear hearing aids, cochlear implant or bone-anchored implant? ☐Yes ☐No

Do you feel your hearing is better in one ear?
☐Yes ☐No
If yes, which ear: ☐Right ☐Left

Was your hearing loss caused by Employment or an Accident? ☐Yes ☐No______________________________

CHECK BOXES THAT YOU ARE INERESTED IN FROM HEARING AID TECHNOLOGY:

☐ Inconspicuous Appearance
☐ Understanding Speech Better
☐ Comfort in Background Noise
☐ Cost
☐ Rechargeable Batteries
☐ Can be connected to cell phone with an app for Bluetooth streaming & adjusting volume & programs
☐ Other: ______________________________

PLEASE LIST THE TOP THREE SITUATIONS WHERE YOU WOULD MOST LIKE TO HEAR BETTER:

1. ______________________________
2. ______________________________
3. ______________________________

DIZZINESS

☐Dizziness – Unsteady/Balance struggles
☐Dizziness – True spinning sensations
☐Dizziness – Lightheadedness
☐Dizziness – Falling down

If there are other medical experiences or symptoms regarding your ears that is not mentioned above, please provide this information here:
____
____

Are you a Veteran? ☐**Yes** ☐**No**

If you are a Veteran, The doctor will go through the following questions with you.

Military Records: ____

____

Military Noise Exposure: ____

____

____

Post Military Noise Exposure: ____

____

____