Hearing and Medical History

Contact

Date (MM/DD/YYYY)

PATIENT INFORMATION

Name _____ _____ _____ Date of Birth _____

First MI Last MM/DD/YYYY

ABOUT YOUR HEARING AND MEDICAL HISTORY

When was your last hearing test? _____ ☐ Never had my hearing tested

Do you experience hearing loss? ☐ Yes ☐ No ☐ Not sure

If you experience hearing loss, please describe it: _____

If yes, which ear(s)? ☐ Right ☐ Left

How was the onset of your hearing loss ☐ Gradual ☐ Fluctuating ☐ Sudden ☐ Congenital ☐ Longstanding

Which ear do you use to talk on the phone? ☐ Right ☐ Left

Do you have a history of hearing aid use? ☐ Yes ☐ No

If yes, please describe: _____

Please check all that apply:

☐ Dizziness Which best describes it? ☐ Constant ☐ Intermittent ☐ Single episode ☐ Lightheadedness

Accompanied by ☐ Hearing Loss ☐ Double vision ☐ Limb weakness ☐ Tingling

☐ Tinnitus/ringing/noises ☐ Right Ear ☐ Left Ear

☐ Ear fullness/pressure ☐ Right Ear ☐ Left Ear

☐ Imbalance Describe: _____

Have you experienced any of the following medical conditions?

☐ Diabetes	☐ Heart problems	☐ Vascular problems	☐ High blood pressure
☐ Cancer	☐ Strokes	☐ AIDS/HIV	☐ Head injury
☐ Autoimmune disease	☐ Genetic disorder	☐ Recent hospitalization	☐ Macular degeneration
☐ Mumps	☐ Measles	☐ Von Recklinghausen NF	☐ Limb tingling/numbness
☐ Encephalitis	☐ Meningitis	☐ Allergies	☐ Changes in cognition
☐ Paget's disease	☐ Double vision	☐ Malaria	☐ Numbness around face

Please list all allergies (food, medication, plastics etc.):

ABOUT YOUR CURRENT MEDICATION

Please list all medication:

Date prescribed	Medication	Dose	Frequency

Do you take blood thinners? ☐ Yes ☐ No

Do you use a pacemaker? ☐ Yes ☐ No

Patient signature:

Please sign here