

Hearing and Medical History

Contact

Date (MM/DD/YYYY)

PATIENT INFORMATION

Name

First

MI

Last

Date of Birth

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

Single episode

Intermittent

Lightheadedness

Accompanied by

Hearing Loss

Limb weakness

Double vision

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