

Patient History Form

Patient Name: _____ **Date:** _____

1. Chief complaint: Hearing Loss (Right ear / Left ear) Tinnitus/Ringing Dizziness
 Difficulty hearing (in Quiet in Noise) Telephone (Right ear Left ear)
2. How long have you noticed this difficulty? _____
3. Is this problem due to a work-related injury/exposure? Yes No
 If so: Date of Injury: _____ Explain: _____
4. Do you feel your hearing is changing? Yes No (Gradual Sudden)
5. Have you ever been exposed to loud noise, either recently or in the past? Yes No
 If so, please mark all that apply:
 Farm Machinery Music Hunting/Shooting Factory Noise
 Power Tools Military Jet Engines Other: _____
6. Have you seen an Ear, Nose and Throat Physician? Yes No
 If so, who did you see? _____ When? _____
7. Have you ever had surgery that may have affected your hearing? Yes No
8. Is there a history of hearing loss in your family? Yes No If so, who? _____
9. Have you ever had an ear infection? Yes No (If yes, as a child as an adult)
10. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?
 Yes No If yes, please describe: _____
11. Do you take any prescription medications on a regular basis? Please list:
 Medication: _____ For: _____
 Medication: _____ For: _____
 Medication: _____ For: _____
12. Please check any of the following that you currently have or have had in the past:
 Arthritis HIV Malaria
 Asthma Head Injury Measles Parkinson's
 Bell's Palsy Heart Trouble Meningitis Sinusitis
 Cancer Hepatitis Mumps Stroke/TIA
 Diabetes High Blood Pressure Neurological Symptoms Visual Trouble-Loss/Sight
13. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
 _____ Improved hearing in quiet _____ Improved hearing in noise
 _____ Cosmetic appearance _____ Expense
14. If you are currently using a hearing aid, or have in the past, please answer the following:
 Which ear is/was aided? Right Left
 How long have you used a hearing aid? _____
 What would improve your current hearing aid? _____