Patient History

Confidential Patient/Client Information

Name: _____ _____ Today Date: _____

Marital Status: Married Single Widow/Widower Divorced Date of Birth: _____

Occupation: _____

Emergency Contact: _____Phone Number: _____

Primary Care Physician: _____Phone Number: _____

Hearing History

Have you ever had your hearing evaluated before? **Y / N** If yes, when: _____

Results? _____

Do you feel that your hearing is better in one ear than the other? **Y / N** Which is better? **L / R**

What concerns you most about your hearing/understanding abilities? _____

_____

_____

What would you like to accomplish during your treatment of your hearing loss? _____

_____

Do you ever experience noises in either ear (ringing, hissing, buzzing, etc.) **Y / N**

If Yes, please explain**:** _____

When did the sound begin? _____

How frequently? Rarely Occasionally Daily Constantly Is it in the **Right** or **Left** or **Both**

Is there a Family history of Hearing Loss? **Y / N**

If Yes, Who? _____ Did they wear hearing devices? _____

Is there a family history of Dementia or Alzheimer's? **Y / N** **Mother or Father** (Please Circle)

Have hearing aids ever been recommended to you for treatment? **Y / N** Worn? **Y / N** Both Right Left

How long have you used hearing devices? _____

Any Concerns regarding your current hearing devices? _____

Type of Devices or Brand? _____ Age of Devices? _____

History of Exposure

Have you been exposed to loud noise, recently or in the past? **Y / N**

Fire Arms Factory work Military Equipment Power Tools Loud Music Farm Equipment

Explosions Heavy Equipment Motorcycles/Recreational Vehicles Other: _____

Please tell us about your experiences with loud noises that might have caused damage to your hearing:

_____

ENT- Doctor of Ears, Nose, and Throat or Physician

Have you seen an ENT or Physician with symptoms of Pain or Discomfort for your ears recently? **Y / N**

When? _____ Who? _____

Do you have a History of Ear Infections? _____When was the last time? _____

Acute or chronic dizziness? **Y / N** Loss of Balance? **Y / N** When did experience dizziness? _____

Have you had COVID or the Flu, in the last year? **Y / N** Prescription? _____ **N/A**

What was the duration of your illness? _____

Did you have complications due to your illness? _____

_____

Have you ever had surgery of the head, neck, or ears? _____ When? _____

Have you ever had Tubes put in your ears? **Y / N** How long ago? _____

Visible evidence of significant cerumen or ear wax? **Y / N** Inflammation or Itchiness of the ear cannel **Y / N**

Do you have Allergies? **Y / N** **Duration: 3 months 6 months 9 months 12 months**

Do you take over the counter decongestion medication for the treatment of allergies? **Y / N**

Please list any medications that you are currently taking: _____

_____

Please list any allergies (food, medication, plastics, metals, etc.) _____

_____

General Medical History

Have you experienced any of the following major medical conditions (please check all that apply):

- ☐ Alzheimer's disease
- ☐ Arthritis/rheumatoid
- ☐ Cancer
- ☐ Cognitive decline
- ☐ Depression or anxiety
- ☐ Diabetes
- ☐ Head injury
- ☐ Heart disease
- ☐ High Blood pressure
- ☐ Macular degeneration/other vision loss/blurred vision
- ☐ Migraines
- ☐ Neurologic symptoms (numbness/muscle weakness/seizures/headaches)
- ☐ Parkinson's
- ☐ Stroke/TIA

Are you experiencing or have you experienced any auditory, balance and/or cognitive symptoms?

Auditory System	Hearing Loss	Yes	No	Chronic
	Tinnitus	Yes	No	Chronic
	Earaches	Yes	No	Chronic
Balance	Dizziness/Vertigo	Yes	No	Chronic
	Imbalance	Yes	No	Chronic
Cognitive	Brain Fog	Yes	No	Chronic
	Difficulty Thinking	Yes	No	Chronic
	Difficulty Remembering	Yes	No	Chronic

Would you like to have more information on the effects of Hearing Loss and the associated risks of Dementia?

Yes / No

Your Goals

Please list, in order of importance, the environments and listening situations where you would like to improve communication:

1. **_____**
2. **_____**
3. **_____**

*Who has encouraged you to come in today? _____