Salyer Hearing Center, PLLC

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HEARING HEALTH HISTORY

Today's Date _____ Patient Name _____ Date of Birth _____

What is the primary reason for your appointment today? _____

Do you feel that you have problems with your hearing? _____

Which ear? Right Left Both

Has your hearing loss been? Gradual Sudden Fluctuating

How long have you had a hearing problem? _____

Do you have a family history of hearing problems? _____

Have you ever had your hearing tested? _____

Have you ever worn hearing aids? _____

Do you have fullness or pressure in your ears? _____

Have you ever been exposed to loud noise? _____

Do you have a history of ear infections? _____

Do you have noise in your ears or head? _____

Do you have dizziness, vertigo or light headedness? _____

Do you have trouble hearing on the telephone? _____

Have you seen a doctor who specializes in ears? _____

Have you ever had any ear surgeries? _____

Do you suffer from any of these chronic medical conditions:

Diabetes	Liver Disease	History of Cancer	HIV/AIDS
Stroke	Thyroid Disease	History of Radiation/Chemotherapy	Bleeding Disorder
Heart Disease	Kidney Failure	Hepatitis A B C	Autoimmune Disease

Please list any medications that you are taking: _____