QUALITY HEARING
& AUDIOLOGY CENTER

2227 N Belt Highway, St. Joseph, MO 64506
TEL 816.233.0022 FAX 816.233.0023
www.hearquality.com

Patient Name: First Last | Age: | Date:

1. What is the primary reason for today's visit:

2. Are you experiencing problems with your hearing? ◯ Yes ◯ No

Which ear? ◯ Both ◯ Right ◯ Left

3. Has the hearing loss been: ◯ Gradual ◯ Sudden ◯ Fluctuating

4. How long have you noticed problems with your hearing:

◯ Recently ◯ 1-3 Years ◯ 4-6 Years ◯ 7-10 Years ◯ More than 10 Years

5. What do you think may have caused this?

6. Have you had your hearing tested before? ◯ Yes ◯ No

If yes, when:

7. What was the outcome of your previous hearing test?

◯ No Loss ◯ Mild Loss ◯ Hearing Aids Recommended ◯ NA

8. Do you currently use a hearing aid? ◯ Yes ◯ No

9. Have you ever used a hearing aid(s)? ◯ Yes ◯ No

10. Do any members of your family have a hearing problem? ◯ Yes ◯ No

11. Do you have a history of ear infections? ◯ Yes ◯ No

12. Have you had any of the following in the last six months? (Select all that apply)

◯ Medically Diagnosed Ear Pathology ◯ Ear Pain
◯ Pressure or Fullness in the Ears ◯ Ear Drainage

13. Have you had surgery on your ears? ◯ Yes ◯ No

If yes, which ear? ◯ Both ◯ Right ◯ Left

14. Do you hear noises in your ears or head? (Tinnitus) ◯ Yes ◯ No

If yes, which ear? ◯ Both ◯ Right ◯ Left

If yes, how often do you hear these noises?

◯ Constantly ◯ Frequently ◯ Occasionally ◯ Very Seldom

15. How would you describe the noise?

◯ Ringing ◯ Buzzing ◯ Roaring ◯ Crickets ◯ Pulsating ◯ NA

16. Are you experiencing any problems with dizziness? ◯ Yes ◯ No

If yes, is your dizziness accompanied by the following?

◯ Nausea ◯ Vomiting ◯ Noises in Ears ◯ Loss of Consciousness

Doctor's Notes:

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17. Do you have or have you had any of the following? (Select all that apply)

- ◯ Sinuses/Allergy
- ◯ Measles
- ◯ Stroke
- ◯ Head Injury
- ◯ AIDS/HIV
- ◯ High Cholesterol
- ◯ Encephalitis
- ◯ Headaches
- ◯ Scarlet Fever
- ◯ Vascular Problems
- ◯ Meningitis
- ◯ Thyroid
- ◯ Heart Attack
- ◯ Arthritis
- ◯ Cancer
- ◯ Chicken Pox
- ◯ Fatigue
- ◯ Heart Problems
- ◯ Typhoid
- ◯ Other: _____
- ◯ Mumps
- ◯ Diabetes
- ◯ High Blood Pressure
- ◯ Appetite Change
- ◯ Blood Disorder
- ◯ Diphtheria
- ◯ Genetic Disorders
- ◯ High Fevers
- ◯ Tonsillitis

18. Do you take medications regularly? (Please list on bottom right) ◯ Yes ◯ No

19. Allergies to medication or plastics? _____

20. Have you ever been exposed to excessively loud noises? ◯ Yes ◯ No

21. Are you currently employed? ◯ Yes ◯ No ◯ Retired

22. What is or was your occupation? _____

Please fill out the below questions:

23. Eye problems? (e.g., blurred vision or pain) ◯ Yes ◯ No

24. Nose, throat or mouth problems? ◯ Yes ◯ No
(e.g., trouble swallowing, nose bleeds, denture issues, pain)

25. Cardiovascular symptoms? ◯ Yes ◯ No
(e.g., hypertension, chest pain, swelling, palpitations, heart surgery)

26. Respiratory symptoms? ◯ Yes ◯ No
(e.g., shortness of breath, cough, wheezing)

27. Gastrointestinal symptoms? ◯ Yes ◯ No
(e.g., nausea, vomiting, weight changes, diarrhea)

28. Musculoskeletal symptoms? ◯ Yes ◯ No
(e.g., joint pain, swelling, recent trauma)

29. Neurological symptoms? ◯ Yes ◯ No
(e.g. numbness, headaches, seizures, muscles weakness)

30. Psychiatric issues? ◯ Yes ◯ No
(e.g., depression, anxiety, compulsions)

31. Endocrine symptoms? (e.g., frequent urination, hot flashes) ◯ Yes ◯ No

32. Hematologic/lymphatic symptoms? ◯ Yes ◯ No
(e.g., bleeding gums, bruising, swollen glands, clotting issues)

33. Allergic/immunologic symptoms? ◯ Yes ◯ No
(e.g., hives, asthma, itching, immune deficiency)

Doctor's Notes:

Medication List: