Abington Audiology & Balance Center

Clarks Summit ● Tunkhannock
570-587-3277

Patient Name: _____ Date: _____

1. Chief Complaint: ☐ Hearing Loss (☐ Right Ear/ ☐ Left Ear/ ☐ Both) ☐ Tinnitus/Ringing ☐ Dizziness
   ☐ Difficulty hearing (☐ in Quiet ☐ in Noise) ☐ Telephone (☐ Right ear ☐ Left ear)

2. How long have you noticed this difficulty? _____

3. Do you think your hearing is changing? ☐ Yes ☐ No (☐ Gradual ☐ Sudden)

4. Have you ever been exposed to loud noises, either recently or in the past? ☐ Yes ☐ No
   If yes, please mark all that apply:
   ☐ Farm Machine ☐ Music ☐ Hunting/Shooting ☐ Factory noise
   ☐ Power Tools ☐ Military ☐ Jet Engines ☐ Other:

5. Do you have any of the following symptoms? ☐ Deformity of the ear ☐ Drainage of the ear ☐ Ear pain ☐ Sudden of rapid loss within the past 90 days ☐ Acute or chronic dizziness/imbalance ☐ Ear Pressure ☐ Tinnitus/Ringing

6. Have you ever had your hearing tested? ☐ Yes ☐ No If so, when was your last test? _____

7. Have you seen an Ear, Nose and Throat Physician? ☐ Yes ☐ No
   If so, who did you see? _____ When? _____

8. Have you ever had surgery on your ears? ☐ Yes ☐ No Type? _____

9. Who is your Primary Physician? _____ Did he/she refer you to us? _____
   Would you like us to send a copy of the report to your primary physician? ☐ Yes ☐ No

10. Is there a history of hearing loss in your family? ☐ Yes ☐ No if so, who? _____

11. Have you ever had an ear infection? ☐ Yes ☐No (If yes, ☐ as a child ☐ as an adult)

12. Do you take any prescription medications on a regular basis? Please list:
    Medication: _____ Dosage: _____ For: _____
    Medicaton: _____ Dosage: _____ For: _____
    Medication: _____ Dosage: _____ For: _____
    Medicaton: _____ Dosage: _____ For: _____
    (if you have a copy of them we will be happy to make a copy of it; if you need more room, please use back of paper)

13. Please check any of the following that you currently have or have had in the past:

Arthritis	Heart Trouble	Measles	Parkinson's
Asthma	Hepatitis	Meningitis	Scarlet Fever
Bell's Palsy	High Blood Pressure	Mumps	Sinusitis
Diabetes	HIV	Neurological	Stroke/TIA
Head Injury	Malaria	Vision Loss	Other: _____

14. If you are currently wearing a hearing aid, or have in the past, please answer the following:
    Which ear is/was aided? ☐ Right ☐ Left ☐ Both
    How long have you used a hearing aid? _____
    Are you satisfied with your current hearing aids? ☐ Yes ☐ No

15. Have you used tobacco products (cigarette, cigar, smokeless tobacco) one of more times in the past 24 months?
    ☐ Yes ☐ No If yes, how often have you used a tobacco product in the past 24 months? _____
    If yes, what type(s) of products have you used? _____