Affordable Hearing, LLC

Adult Hearing History

Today's Date_____/_____/_____

Name_____ D.O.B._____/_____/_____ Age_____

Address_____ Sex: Male☐ Female☐

City_____ State_____ Zip_____

Email_____

Accompanying Party Name_____ Relationship_____

Telephone: Work_____ Home_____

Current Occupation_____ Referred by_____

Health Insurance_____ | _____
Company Name Member Number

Have you ever had a hearing test? Yes☐ No☐ If Yes, When_____ Where_____

Have you ever had Surgery on your ears? Yes☐ No☐ If Yes, Explain_____

_____

Do you have a hearing problem? Yes☐ No☐ If Yes, is it: Mild☐ Moderate☐ Severe☐

How long have you had the loss?_____ Is your hearing loss fluctuating? Yes☐ No☐

Do you have a history of sudden or rapidly progressive hearing loss within the previous 90 days? Yes☐ No☐

If you responded Yes to the above question, is your sudden hearing loss: Right Ear☐ Left Ear☐ Both Ears☐

Which ear do you have greater difficulty hearing? Right☐ Left☐ Unsure☐

Do you have trouble hearing in any of the following situations?

Telephone	Yes☐	No☐	Men talking	Yes☐	No☐
At social gatherings	Yes☐	No☐	One on One talking	Yes☐	No☐
Background noise	Yes☐	No☐	Women talking	Yes☐	No☐
Television	Yes☐	No☐	Other (please list)_____		

Are you currently taking any prescription or nonprescription drugs? Yes☐ No☐ For what...?

Please list_____

Present Symptoms / Do you have:

Noises/Tinnitus in your ears? Yes☐ No☐ If Yes: Right☐ Left☐ Both☐ Is it: Constant☐ Periodic☐

Do you have ear pain, or discomfort? Yes☐ No☐ Right☐ Left☐ Both☐

Any history of, or active drainage from the ears within the previous 90 days? Yes☐ No☐

Do you have a history of ear infections? Yes☐ No☐

Do you currently have: Nausea☐ Headaches☐ Chronic Dizziness/Vertigo☐

Have you fallen in the last year? Yes☐ No☐ List how many times and when_____

_____

Adult Hearing History

Primary Doctor's Name_____

Doctor's Office Location_____

Are you currently being treated by this Primary Dr., or another Dr. for ear problems of any kind? Yes☐ No☐

If yes, Explain_____

May we have permission to contact your doctor(s) to send your Audiologic Records*: Yes☐ No☐

If Yes, Please Sign **X**_____

(*Includes Your Audiologic Report & Audiogram)

Have you ever been exposed to excessive noise levels without hearing protection: Yes☐ No☐

Where? Job☐ Military☐ Recreation☐ (i.e., music☐ firearms☐ motorcycles☐ aircraft☐ power tools☐), Other:_____

Do you have, or have you had:

☐Diabetes	☐Hypoglycemia (low blood sugar)	☐Vertigo (spinning)
☐Imbalance	☐Other dizziness	☐High blood pressure
☐Low blood pressure	☐History of migraines	☐Heart disease
☐Kidney disease	☐HIV or Aids	☐High fever
☐Stroke	☐Serious head trauma	☐Falling experiences

To your knowledge, have you ever received: *Intravenous Antibiotics*: ☐Yes ☐No *Quinine:* ☐Yes ☐No

Chemotherapy: ☐Yes ☐No *High dose Vicodin:* ☐Yes ☐No *High dose Aspirin:* ☐Yes ☐No

Do you have any family member(s) with hearing loss? ☐Yes ☐No Who?_____

When did the family member(s) lose hearing? ☐Birth ☐Mid-life ☐Late-onset

Do you now, or have you ever worn a hearing aid? ☐Yes ☐No If Yes? ☐Right ☐Left ☐Both

Year_____Make_____Model_____

Is it satisfactory? ☐Yes ☐No If Not, why?_____

Have you performed any research on hearing aids? ☐Yes ☐No If Yes, explain_____

_____

_____

(THIS SECTION IS FOR OFFICE PERSONAL ONLY)

Visible congenital or traumatic deformity to the ear(s)? ☐Yes ☐No

Audiometric air-bone gap equal to, or greater than, 15dB at 500Hz, 1000Hz, and 2000Hz? ☐Yes ☐No

Comments/Observations_____

_____

PCC_____ HCP_____