____
Date

____
Patient Name

What prompted you to visit our office today?____

What would you like achieve from your visit?____

What have you noticed about your hearing ability?____

How long have you had difficulty hearing?____

What are others saying about your hearing ability?____

Have you had a hearing test before?_____ If so, by whom?________________ Date:________________

Yes No

___ ___ Do you have any pain or discomfort in your ear?______________________________________

___ ___ Do you have any noise/ringing in your ears?____

___ ___ Is there a history of hearing loss in your family?______________________________________

___ ___ Do you have any dizziness or vertigo?____

___ ___ Do you have a history of excessive noise exposure?____________________________________

___ ___Have you had any ear drainage in the past 90 days?____________________________________

___ ___ Have you had ear surgery in the past 90 days?____

___ ___Have you had a sudden change in your hearing in the past 90 days?________________________

Please list all medications that you are currently taking____

____

Do you have any medical conditions we need to be aware of?___________________________________

____

Who is your primary care physician?____

How were you referred to our office?____