Alexandria Audiology

Hearing Health Interview

_____ _____

Patient Name Date

What prompted you to visit our office today? _____

What would you like to achieve from your visit? _____

What have you noticed about your hearing ability? _____

How long have you had difficulty hearing? _____

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

Yes	No	
___	___	Do you have any pain or discomfort in your ear(s)? _____
___	___	Do you have any noise / ringing in your ear(s)? _____
___	___	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 should know about?

_____

Who is your primary care physician?

_____

How were you referred to our office?

_____