ADULT MEDICAL HISTORY

Please select all current symptoms:

- ☐ Hearing Loss (RIGHT/LEFT/BOTH)
- ☐ Tinnitus/Ringing (RIGHT/LEFT/BOTH)
- ☐ Dizziness
- ☐ Ear Pain or drainage

Onset of hearing loss: (SUDDEN/GRADUAL/FLUCTUATING)

When did you first notice the hearing loss? _____

Have you ever had your hearing tested? (YES/ NO)

When: _____ Where: _____

Have you ever worn a hearing aid? (YES/ NO) If yes, please briefly describe your experience:

_____

Do you have a history of excessive noise exposure? (YES/ NO)

- ☐ Firearms
- ☐ Lawn Equipment
- ☐ Military noise
- ☐ Power tools
- ☐ Music/Concerts
- ☐ Other: _____

Please check any of the following medical conditions that you have experienced:

- ☐ Arthritis
- ☐ Bell's Palsy
- ☐ Meningitis
- ☐ Diabetes
- ☐ Head Injury
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Parkinson's Disease
- ☐ Ear Surgery
- ☐ Measles/Mumps
- ☐ Cognitive Decline
- ☐ Cancer:_____
- ☐ Heart Problems
- ☐ Ear Infections

Radiation (Y/N)
Chemotherapy (Y/N)

Medications: _____