HEALTH HISTORY

Please Complete the FRONT & BACK sides

Date: _____ **Patient Name:** _____ **DOB:** _____

Have you had your hearing tested before ❑ Yes ❑ No ❑ Not Sure
If yes, when? _____ What were the results? _____

Do you think you have a hearing problem? ❑ Yes ❑ No ❑ Not Sure
Which ear is your better ear? ❑ Right ❑ Left ❑ Not Sure
When did you first notice your hearing problem? _____
Has the hearing loss been: ❑ Gradual ❑ Sudden ❑ Fluctuating
Do you have ringing or noise in your ears? ❑ Yes ❑ No ❑ Not Sure

Please check those that apply:

- ❑ Frequent ear infections
- ❑ Draining/bleeding ears
- ❑ Sudden loss of hearing in the last 90 days
- ❑ Ear pain, swelling/tenderness in the last 90 days
- ❑ Fullness or pressure in the ears
- ❑ Head, neck, sinus, or ear surgery
- ❑ Family History of hearing loss
- ❑ Acoustic trauma (firecrackers, loud sounds)
- ❑ Dizziness
- ❑ Popping sensation in the ear
- ❑ Frequent head colds, sinus/allergy problems
- ❑ Headaches
- ❑ Low / High Blood pressure problems
- ❑ Head trauma with loss of consciousness
- ❑ Vision problems
- ❑ TMJ (jaw pain, clicking, or popping)
- ❑ Reduced cognitive ability

- ❑ Measles, Mumps, Rubella
- ❑ Pneumonia
- ❑ Meningitis
- ❑ Tuberculosis
- ❑ Cerebral Palsy
- ❑ High fever
- ❑ Scarlet Fever
- ❑ Hepatitis A, B, or C
- ❑ Polio
- ❑ Stroke
- ❑ Herpes
- ❑ Epilepsy
- ❑ Cancer: _____ Chemo? Y N
- ❑ Kidney Problems
- ❑ AIDS/ HIV positive
- ❑ Compromised immune system such as RA
- ❑ Radiation to head or neck
- ❑ Diabetes
- ❑ Pacemaker
- ❑ Blood Thinner
- ❑ Routine MRI
- ❑ Hypo / Hyper Thyroid
- ❑ Smoking
- ❑ Other: _____

How would you describe your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please list any medications (including over-the-counter and supplements) you take regularly:

_____

Are any of the above medications:
- a blood thinner? ❑Yes: _____ ❑ No ❑ Not Sure
- a diuretic (water pill): ❑Yes: _____ ❑ No ❑ Not Sure

Noise Exposure:

Have you ever been exposed to loud noise, recently or in the past? ❑Yes ❑ No ❑ Not Sure

Please indicate the types of noise:

- ❑ Power tools
- ❑ Power lawn mowers/leaf blowers
- ❑ Military tanks or other equipment
- ❑ Aircraft
- ❑ Motorcycles
- ❑ Factory work / Farm equipment
- ❑ Loud music
- ❑ Explosions
- ❑ Heavy Equipment
- ❑ Gunfire (shoot with ❑ Right ❑ Left hand)

Are you exposed to noise daily?	❑Yes	❑ No	❑ Not Sure
Have you been exposed to noise in the last 24 hours?	❑Yes	❑ No	❑ Not Sure
Have you ever worn hearing protection?	❑Yes	❑ No	

If yes, what type? _____

Tinnitus (ringing or sounds in the ear)

If you have ringing, in which ear?	❑ Right	❑ Left	❑ Both
Is it louder in one ear than the other?	❑ Right	❑ Left	❑ Both

How often do you hear it? _____

In what situations?_____

Hearing Aid History

Have you ever worn or tried hearing aid(s)?	❑Yes	❑ No	
When were you fit? _____			
Do you still wear hearing aid(s) now?	❑Yes	❑ No	
Which ears?	❑ Right	❑ Left	❑ Both

Describe your experience: _____

Where Do You Experience Hearing Challenges?	***Always***	***Sometimes***	***Never***
1) I have to ask people to repeat themselves even when I am in quiet situations			
2) My Family members complain that I need to turn the TV volume louder than they do			
3) When I talk on the phone I miss some of what is being said			
4) During a game around a table I have difficulty hearing the conversation			
5) When I am in a busy public place such as a mall, I have difficulty communicating with others			
6) In meetings I have to strain to make sure I hear everything			
7) When I'm eating in a restaurant, I have to ask my dining companion to repeat things			
8) I miss a lot of information during church and/or classroom lectures.			
9) When I'm listening to music/concerts, I miss parts of the performance.			
10) If I'm in the car with others who are talking, I can't hear what they're saying			