*Health History*

**Please Complete the FRONT & BACK sides**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_

Do you think you have a hearing problem?   Yes  No  Not Sure

Which ear is your better ear?  Right  Left  Not Sure

Has the hearing loss been:  Gradual  Sudden  Fluctuating

When did you first notice your hearing problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you had your hearing tested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have tinnitus?  Yes  No

Is your tinnitus bothersome?  Yes  No

*if you answered “yes” please fill out the Tinnitus History Intake Questionnaire (page 3-4)*

**Medical History - Please check those that apply:**

* Frequent ear infections
* Draining/bleeding ears
* Sudden loss of hearing in the last 90 days

 Right  Left  Both

* Ear pain, tenderness or swelling in the last 90 days

 Right  Left  Both

* Fullness/pressure in the ears
* Frequent head colds. Sinus/allergy problems
* Popping sensation in the ear
* Family history of hearing loss
* Dizziness
* Headaches
* TMJ (jaw pain, clicking)
* Acoustic trauma (firecrackers, loud sounds)
* Reduced cognitive ability
* Head trauma with loss of consciousness
* Vision problems

 Glasses  Other \_\_\_\_\_\_

* Surgery to:

 Head  Neck  Sinus  Ear

* Measles
* Mumps
* Rubella
* Pneumonia
* Meningitis
* Epilepsy
* Cerebral Palsy
* High fever
* Scarlet Fever
* Herpes
* Polio
* Stroke
* Cardiac problems
* Blood Disease (anemia)
* Hepatitis A, B or C
* Tuberculosis
* Vascular Disease
* Multiple Sclerosis
* Lyme Disease
* Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_

Chemo?  Yes  No

* Kidney Disease
* AIDS/ HIV positive
* Compromised immune system such as RA
* Hyper Thyroid
* Hypo Thyroid
* Daily Alcohol consumption \_\_\_\_\_/ day
* Daily Caffeine intake \_\_\_\_\_ / day
* Smoking or tobacco use

 Tobacco  Other

* Routine MRI
* Radiation to head or neck
* Diabetes
* Pacemaker
* High Blood pressure

Under control?  Yes  No

* Low Blood pressure

Under control?  Yes  No

* Currently taking a blood thinner
* Currently taking a diuretic
* Daily Aspirin dosage\_\_\_\_\_
* Other medical conditions you feel are important for us to know: \_\_\_\_\_\_\_\_\_\_

Have you ever taken any of the following medications? Dihydrostreptomycin Gentamicin

Kantamycin Neomycin Quinine Streptomycin Vancomycin

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

Please list or provide us with a list or a copy of medications (including over-the-counter and supplements) you take regularly, include dosage, frequency and route: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hearing Aid History:**

Have you ever worn or tried hearing aid(s)? Yes  No When?\_\_\_\_\_\_

Do you still wear hearing aid(s) now? Yes  No

Which ears?  Right  Left  Both

Describe your experience: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle:**

Hobbies/ Interests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| ***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 |  |  |  |
| 1. My Family members complain that I need to turn the TV volume louder than they do |  |  |  |
| 1. When I talk on the phone I miss some of what is being said |  |  |  |
| 1. During a game around a table I have difficulty hearing the conversation |  |  |  |
| 1. When I am in a busy public place such as a mall, I have difficulty communicating with others |  |  |  |
| 1. In meetings I have to strain to make sure I hear everything |  |  |  |
| 1. When I’m eating in a restaurant, I have to ask my dining companion to repeat things |  |  |  |
| 1. I miss a lot of information during church and/or classroom lectures. |  |  |  |
| 1. When I’m listening to music/concerts, I miss parts of the performance. |  |  |  |
| 1. If I’m in the car with others who are talking, I can’t hear what they’re saying |  |  |  |