Patient History Information

Name______________________________________

MEDICAL HISTORY

Yes No Have you seen a doctor in the past six months regarding your ears or hearing?
Yes No Have you ever had your hearing tested?
If yes, when___________by whom__________________________
Yes No Have you ever had any type of ear surgery?
If yes, type of surgery____
Yes No Do you take medicine every day?
For what condition ____
Yes No Do you have any other medical conditions that might be related to your ears or hearing?
If yes, explain ____

ABOUT YOUR EARS:

Do you have any of these symptoms?

Yes No Deformity of the ear
Yes No Drainage from the ear
Yes No Sudden or rapid loss of hearing in the past 90 days
Yes No Acute or chronic dizziness
Yes No Ringing in the ears
Yes No Chronic ear infections
Yes No Have you ever seen a doctor for wax removal?
Yes No Do you ever have pain in your ears?
Yes No Is there a concern of Speech and Language delay? (for child)
Which is your poorer ear? Same Right Left

ABOUT YOUR HEARING:

Do you experience difficulty with the following?

Yes No Understanding conversation
Yes No Hearing in a crowd
Yes No Hearing by telephone
Yes No Hearing television
Yes No Does anyone else in your family have a hearing problem?
What relationship?____
Yes No Do you now or have you ever worn a hearing aid?
If yes, how long ago was it purchased____________________
How long have you had a hearing problem?_____________________________

Who referred you to us?____

Signature______________________________________ Date_______________