



Improve Your Hearing...Improve Your Life!

Phone: 907.789.6780

Fax: 907.789.5828

Text: 907.465.7755

northlandaudiology.com
juneauhearing@gci.net

Jordan Creek Center
8800 Glacier Hwy, Ste 116
Juneau, Alaska 99801

Mary Frances Towers
Monthly Clinic
320 Bawden St, Ste 304
Ketchikan, Alaska 99901

Patient History Form (Page 1 of 2)

Date: _____

Patient name: _____ Date of Birth: _____ Gender: Male Female
(First, Middle Initial, Last)

1. Why are you coming to see us? _____

2. Any prior hearing tests? ____ Yes ____ No
If YES, when and where? _____

3. What were the results? (If available, a copy of the report is helpful) _____

4. Is there a family history of hearing loss? ____ Yes ____ No
If YES, please describe: _____

5. How has your hearing worsened? (Please circle one) Suddenly Gradually
Please describe: _____

6. When did you first notice you had trouble hearing? _____

7. Do you think your hearing is worse in one ear? (Please circle one) Right Left Both

8. What do you think may have caused your hearing loss? _____

9. Do you have ringing (or other unusual sounds) in your ears? ____ Yes ____ No
If YES, please describe: _____

10. Are you experiencing any of the following? (Please circle all that apply)
Earache or ear pain Ear fullness Pressure Ear drainage Severe dizziness

11. Have you ever had or are you scheduled to have any of the following:
a. Wax clinically removed from your ears? ____ Yes ____ No
If YES, when and how often? _____

b. Ear infection(s)? ____ Yes ____ No
If YES, when and how often? _____

c. Ear surgery? ____ Yes ____ No
If YES, when, where, and why? _____

12. Have you had any of the following illnesses? (Please circle all that apply) Measles Mumps Rubella

13. If you've had cancer and received radiation therapy or chemotherapy, please list type(s) of cancer and the name(s) of the drugs used: _____

14. Do you have a history of high blood pressure? ____ Yes ____ No

15. Do you have a history of diabetes? ____ Yes ____ No
If YES, what type and for how long? _____

(PLEASE TURN OVER FOR PAGE 2)

Patient History Form (Page 2 of 2)

16. Do you have a history of heart disease? Yes No

If YES, please describe? _____

17. a. Do you currently use tobacco (including smokeless tobacco)? Yes No

b. Have you used tobacco (including smokeless tobacco) in the past? Yes No

If YES to 17a/17b, how long have you/did you smoke? _____

c. Are you/have you been exposed to second hand smoke frequently? Yes No

If YES to 17c, how long were you exposed? _____

18. Please describe any other serious health problems: _____

19. Please describe your daily caffeine consumption: _____

20. Are you under high stress at this time? Yes No

If YES, please describe: _____

21. Have you been exposed to loud noises? Yes No

If YES, please describe: _____

a. If at work, please describe: _____

b. If in the military service, when? _____

c. Which ear(s) received the greatest noise exposure? (Please circle one) Left ear Right ear Both sides equally

d. The loud noise was constant intermittent? Please describe: _____

22. How long ago did the loud noise exposure begin? _____

23. Which loud hobbies/activities do you engage in? _____

24. Please answer the following questions: **If you currently use hearing aids, please answer according to how you hear **without** them**

a. Do you have trouble understanding TV programs? Yes No Sometimes

b. Do you have trouble hearing on the telephone? Yes No Sometimes

c. Do you have trouble hearing in background noise? Yes No Sometimes

d. Do you have trouble hearing in quiet situations? Yes No Sometimes

e. Does your hearing difficulty interfere with your job? Yes No Sometimes

f. Does your hearing difficulty interfere with your family life? Yes No Sometimes

g. Does your hearing difficulty effect your hobbies or social life? Yes No Sometimes

h. Does your hearing difficulty interfere with the enjoyment of music? Yes No Sometimes

25. Do other people suggest that you have a hearing problem? Friends Family Co-workers

If yes, please explain why: _____

26. Is there anything else that has been bothering you about your hearing? _____

27. Have you ever used a hearing aid? Yes No

If YES, which side(s)? (Please circle one) Right Ear Left Ear Both Ears

28. If you currently use a hearing aid(s) or if you have used them in the past, please describe your experiences, both positive and negative:

Positive: _____

Negative: _____