NORTHLAND AUDIOLOGY & Hearing Services

Improve Your Hearing…Improve Your Life!

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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. Have you had 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 at a *young age*? ___ *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. Ear infection(s)? ___ *Yes* ___ *No*
       If *YES*, when and how often? _____
    b. 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*
16. Do you have a history of heart disease? ___ *Yes* ___ *No*

(PLEASE TURN OVER FOR PAGE 2)

Patient History Form

17. a. Have you used tobacco (including smokeless tobacco)? ___ *Yes* ___ *No*

If *YES*, how long have you/did you smoke? _____

b. Are you/have you been exposed to second hand smoke frequently? ___ *Yes* ___ *No*

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 (including guns, loud motors, etc.)? ___ *Yes* ___ *No*

If *YES*, please describe: _____

_____

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

b. The loud noise was _____constant _____ intermittent? Please describe: _____

_____

22. Which loud hobbies/activities do you engage in (including hunting, boating, woodworking, etc.)? _____

_____

23. 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

24. Do other people suggest that you have a hearing problem? _____ Friends _____ Family_____ Co-workers

If yes, please explain why: _____

_____

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

_____

26. Have you ever used a hearing aid? ___ *Yes* ___ *No*

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

27. 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: _____