Improve Your Hearing…Improve Your Life!

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Patient History Form

Date: _______________

Patient name: ____ Date of Birth: _________________ Sex: Female Male

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? *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? *Left Ear* *Right Ear* *Equal in Both Ears*

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 check all that apply)*

    Earache or ear pain *Ear fullness* *Pressure* *Ear drainage* *Severe dizziness*

11. Have you ever had ear infection(s)? *Yes* *No*
    If *YES*, when and how often? ____

12. Have you ever had *or* are you scheduled to have ear surgery? *Yes* *No*
    If *YES*, when, where, and why? ____

13. Have you had any of the following illnesses? *(Please check all that apply)* *Measles* *Mumps* *Rubella*

14. If you've received radiation therapy or chemotherapy, list type(s) of cancer & the name(s) of the drugs used:

____

15. Do you have a history of high blood pressure? *Yes* *No*

16. Do you have a history of diabetes? *Yes* *No*

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

18. Describe any other serious health problems: ____

____

19. Are you under high stress at this time? *Yes* *No*
    If *YES*, please describe: ____

20. 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*

21. Describe your daily caffeine consumption: ________________

22. 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? *Left Ear* *Right Ear* *Both Ears*

b. The loud noise was *(Please choose one)* *constant* *intermittent*

Please describe: ________________

23. Do you engage in loud hobbies/activities (including hunting, boating, woodworking, etc.)? *Yes* *No*

If *YES*, please list: ________________

24. Do other people suggest that you have a hearing problem? *Yes* *No*

If *YES*, who? (Please select all that apply) *Friends* *Family* *Co-workers*

If *YES*, what have they said?:________________

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

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

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

Positive: ________________

Negative: ________________

27. Is there anything else that has been bothering you about your hearing that you'd like us to know about?

____

____

28. Please answer the following questions. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer according to the way you hear *with* the aid.

Question			
a. Does a hearing problem cause you to feel embarrassed when you meet new people?	*Yes*	*Sometimes*	*No*
b. Does a hearing problem cause you to feel frustrated when talking to members of your family?	*Yes*	*Sometimes*	*No*
c. Do you have difficulty hearing when someone speaks in a whisper?	*Yes*	*Sometimes*	*No*
d. Do you feel handicapped by a hearing problem?	*Yes*	*Sometimes*	*No*
e. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	*Yes*	*Sometimes*	*No*
f. Does a hearing problem cause you to attend religious services less often than you would like?	*Yes*	*Sometimes*	*No*
g. Does a hearing problem cause you to have arguments with family members?	*Yes*	*Sometimes*	*No*
h. Does a hearing problem cause you difficulty when listening to TV or radio?	*Yes*	*Sometimes*	*No*
i. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	*Yes*	*Sometimes*	*No*
j. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	*Yes*	*Sometimes*	*No*

For Staff Use: ________ ________ ________