



Patient History

Name: _____ Date of Birth: _____

Address: _____ City: _____

Zip Code: _____ Email: _____

Home Phone: _____ Work Phone: _____

Who referred you to EAR Audiology? _____

Please indicate any concerns you have. Check all that apply:

- Hearing loss
 - Difficulty understanding soft speech
 - Difficulty understanding in noise
 - Difficulty hearing on the telephone
 - Noises in your ears (tinnitus): Right Left Both
 - Dizziness
 - Imbalance
 - Please specify any others: _____
- _____
- _____

Describe your hearing:

- | | | | |
|---------------------------------------|---------------------------------|----------------------------------|----------------------------------|
| In which ear do you hear better? | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Unknown |
| How fast did your hearing change? | <input type="checkbox"/> Sudden | <input type="checkbox"/> Gradual | <input type="checkbox"/> Unknown |
| Has it gotten worse over time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Does it change from time to time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Does hearing loss run in your family? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
- _____
- _____

Have you ever had a hearing test? Yes No Unknown

Have you ever had any exposure to:

- | | | | |
|-------------------------------|------------------------------|-----------------------------|----------------------------------|
| Loud noises? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Harsh chemicals or fumes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Intravenous (IV) antibiotics? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Cancer-fighting medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

Hearing Aids

Have you ever worn or wear hearing aids? Yes No

If yes, please answer the following questions:

Which ear was/is aided? Right Left Both

How long have you used hearing aids? _____

Are you satisfied with the aids? Yes No

Medical History

Check any of the illnesses/disorders you have or had in the past:

- | | | |
|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Metabolic disorders | <input type="checkbox"/> Headaches | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Ear wax build-up | <input type="checkbox"/> Fullness of ear | <input type="checkbox"/> Ear aches/pains |
| <input type="checkbox"/> Draining ear | <input type="checkbox"/> Blood pressure problems | |
| <input type="checkbox"/> Allergies: _____ | | |
| <input type="checkbox"/> Facial numbness | <input type="checkbox"/> Numbness of an arm or leg | |

When did the numbness occur? _____ How long did it last? _____

Have you had any injuries to your ears, head, or neck? Yes No

If yes, please describe: _____

What medical treatment (medicine or surgery) have you received for the conditions noted above? Please include the name of the physician and the dates of treatment: _____

Please provide any other information you feel EAR Audiology should know: _____