EAR Audiology, Inc.
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San Diego, CA 92130

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(760) 652-1652 fax
www.earaudiology.com

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: ______________________________

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Describe your hearing:

In which ear do you hear better?	☐ Right	☐ Left	☐ Unknown
How fast did your hearing change?	☐ Sudden	☐ Gradual	☐ Unknown
Has it gotten worse over time?	☐ Yes	☐ No	☐ Unknown
Does it change from time to time?	☐ Yes	☐ No	☐ Unknown
Does hearing loss run in your family?	☐ Yes	☐ No	☐ Unknown

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Have you ever had a hearing test?	☐ Yes	☐ No	☐ Unknown

Have you ever had any exposure to:

Loud noises?	☐ Yes	☐ No	☐ Unknown
Harsh chemicals or fumes?	☐ Yes	☐ No	☐ Unknown
Intravenous (IV) antibiotics?	☐ Yes	☐ No	☐ Unknown
Cancer-fighting medications?	☐ Yes	☐ No	☐ 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:

☐ Cancer	☐ Diabetes	☐ Kidney problems
☐ Metabolic disorders	☐ Headaches	☐ Frequent colds
☐ Ear wax build-up	☐ Fullness of ear	☐ Ear aches/pains
☐ Draining ear	☐ Blood pressure problems	

☐ Allergies: ____

☐ Facial numbness ☐ 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: ____

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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: _______________________________________

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

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