History Form

Name: _____Date: _____

Date of Birth: _____

1. What prompted your visit today? _____

2. Have you had your hearing tested before? □Yes □ No If so, Where? _____

   When? _____ Do you know the results? _____

3. Do you have a family history of hearing loss? □Yes □ No

   Explain: _____

4. Does one ear hear better than the other? □Yes □ No If so, which ear? □ Right □ Left

5. Do you have a history of loud noise exposure? □Yes □ No

   Explain:_____

6. Do you have a history of tinnitus? (Ringing/buzzing/hissing sounds in the ears)? □Yes □ No

7. Do you experience dizziness or imbalance? □Yes □ No Have you in the past? □Yes □ No

   Explain: _____

8. Have you ever experienced a sudden change in hearing? □Yes □ No

   Explain: _____

9. Do you have a history of ear infections or surgeries? □Yes □ No If so, which ear? □ Right □ Left

   Explain: _____

10. Do you experience any pain, fullness or pressure in the ears? □Yes □ No
    If so, which ear? □ Right □ Left

11. Do you have active drainage from any ear? □Yes □ No If so, which ear? □ Right □ Left

12. Do you have significant ear wax accumulation? □Yes □ No

13. Do you have a history of head injuries or ear injuries? □Yes □ No

Explain: _____

14. Are you on any medications? □Yes □ No If so, please list them below.

Medication	Condition	Dosage	Frequency

* If you require more space, please include a full medication list, or ask for another paper.

15. Please check all that apply to your medical history:

□ Diabetes □ High Blood Pressure □ High Cholesterol

□ Cerebral Vascular Accident (CVA) □ Migraines □ Sinus Infections

□ Sudden Hearing Loss □ Tinnitus □ TMJ

□ Heart Disease □ Cancer □ Dizziness

16. Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more in the past 24 months? □Yes □ No

a. If yes, how often have you used tobacco product in the past 24 months? _____

b. If yes, what type(s) of products have you used? _____

17. Do you have difficulty hearing in crowds / in situations with background noise? □Yes □ No

18. Which of these situations are giving you the most difficulty (**check all that apply**)

□ Spouse/Family Members □ Restaurants □ Social settings □ Television/Radio

□ Hobbies (_____) □ Telephone □ Place of Worship □ Movie Theater

□ Work (_____) □ Meetings □ Group Gatherings □ Other

19. If they are not listed above, please describe which other listening situations give you the most difficulty

_____