

Full Name \_\_\_\_\_

Date \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**1. Do you have or have you had any of the following? (Mark all that apply)**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Hearing Problems  | <input type="checkbox"/> Ear Deformity or Injury    | <input type="checkbox"/> Head Injury       | <input type="checkbox"/> Pacemaker        |
| <input type="checkbox"/> Sound Sensitivity | <input type="checkbox"/> Ear Drainage               | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Tobacco Usage    |
| <input type="checkbox"/> Ear Infections    | <input type="checkbox"/> Pressure / Fullness in Ear | <input type="checkbox"/> Punctured Eardrum | <input type="checkbox"/> Unlisted Problem |
| <input type="checkbox"/> Ear Surgery       | <input type="checkbox"/> Sudden Hearing Loss        | <input type="checkbox"/> Stroke            |   |
| <input type="checkbox"/> Ear Pain          | <input type="checkbox"/> Ear Noises / Tinnitus      | <input type="checkbox"/> Diabetes          |   |

2. Do you have any relatives with hearing loss that started before age 70? YES  NO

3. Do your loved ones say that you have a hearing problem? Who? \_\_\_\_\_ YES  NO

4. When was the last time you had your hearing tested? \_\_\_\_\_

5. Where was your hearing tested? \_\_\_\_\_

6. Were you told that you have a hearing problem? \_\_\_\_\_

7. If you think you have hearing loss, in which situations do you have difficulty hearing?

8. If you have hearing loss, for how long have you noticed it? \_\_\_\_\_

9. Do you wear or have you worn hearing aids in the past? YES  NO

If yes, when and where did you get them?

\_\_\_\_\_

If yes, are you currently experiencing problems with them? \_\_\_\_\_

10. Is there anything else you would like us to know about your hearing?

11. Please list any other medical issues you are currently experiencing.

12. List any medications you are taking (exclude vitamins):