# ACADIAN HEARING & SPEECH SERVICES

Name:_____________________________________ Today's Date:_____/_____/_________ Age:________

What is the primary reason for your visit today?______________________________________________________________________

## MEDICAL HISTORY

**Do you have now or ever had the following: (please circle all that apply)**

Diabetes
Arthritis
Hepatitis
Irregular heartbeat
Drug addiction

High Blood Pressure
Cancer
____Radiation
____Chemotherapy
Seizure disorder
Heart attack
Parkinson's Disease

Stroke
Asthma
HIV/AIDS
Dementia

Kidney disease
Chronic lung disease
Eye disease
___Glaucoma
___Macular degeneration
Alcoholism
Alzheimer's Disease

Thyroid problem
Tuberculosis
Psychiatric treatment

*Any other problems not listed*_____________________________________________________________________________

List and date any operations you have had_________________________________________________________________

**List all medications (including vitamins and over-the-counter medicines) below and what they are for (please list additional medications on the back):**

| Medication | Medical Condition | Dosage |
|---|---|---|
| | | |
| | | |
| | | |
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## HEARING INFORMATION

How do you feel your hearing is?_____________________________________________________________________________

Describe where you are noticing hearing difficulties_________________________________________________________

Have you ever had a hearing test before? *Yes* *No* If yes, briefly what were the results?
_________________________________________________________________________________________________________

If recommended, are you motivated to improve your hearing? (please circle) *Yes* *No*

Have you ever worn a hearing aid? *Yes* *No* If yes, briefly describe the hearing aid style, make, year purchased, and which ear_________________________________________________________________________________________

Does hearing loss run in your family? *Yes* *No* If yes, whom?____________________________________

Do you have a history of exposure to noise? *Yes* *No* Describe (hunting, occupational, carpentry, etc):_____________________________________________________________________________________________

Do you have any tinnitus (i.e., ringing, hissing, buzzing, etc.)? *Yes* *No*
If yes, when did it first begin?_________________________ Which ear?_________________________
For how long does it last?_________________________________________

Do you have any dizziness, vertigo, loss of balance, or lightheadedness? *Yes* *No*
If yes, when did it first begin?______________________ How long does it last?________________________________________
How often does it occur?____________________________________