Platte Valley Hearing Center – Hearing Health History (Online Version)

Date: _____

Name: _____

Allergies to foods and/or medications: _____

_____

Medications you are currently taking: _____

_____

_____

Have you ever had Ear Surgery: _____ If Yes, please list: _____

_____

Do you have:

Hearing Loss? _____

If so, in which Ear? _____ R _____ L _____ Both

Sounds in your ears (ringing, buzzing, roaring, etc) ? _____

If so, in which Ear? _____ R _____ L _____Both

Fullness or Stiffness in your ears? _____

If so, in which Ear? _____ R _____L _____ Both

Pain or Ache in your ears? _____

Itching or Irritation? _____

Dizziness or Balance Trouble? _____

If so, please explain: _____

Have you ever been exposed to excessively loud noise levels? _____ How? _____

Do you have Hearing Aids at this time? _____

If so, are they Helpful? _____

How long have you worn them? _____

Would you like to receive our free informational quarterly newsletter regarding hearing loss and hearing technology? _____