HEARING HEALTH HISTORY

Name (Legal Name) _____ Preferred Name _____

Date of Birth _____

1. Have you ever had a hearing test? ☐ Yes ☐ No
   If yes, Where? _____ When? _____
2. Do you have difficulty hearing? ☐ Yes ☐ No
   If yes, describe some situations you have difficulty hearing?
   _____
3. Does your difficulty hearing affect ☐ Both Ears ☐ Right Ear ☐ Left Ear? Comment _____
4. Has your difficulty hearing been ☐ Sudden or ☐ Gradual? Comment _____
5. Do you have tinnitus (ringing, buzzing, hissing, etc.)? ☐ Yes ☐ No Comment _____
   If yes, do you have tinnitus in ☐ Both Ears ☐ Right Ear ☐ Left Ear?
6. Any medical problems with your ears, ear surgeries or ear infections? ☐ Yes ☐ No Comment _____
7. Do you have ear pain? ☐ Yes ☐No If yes, ☐ Both Ears ☐ Right Ear ☐ Left Ear?
8. Do you have ear fullness/pressure? ☐ Yes ☐ No If yes, ☐ Both Ears ☐ Right Ear ☐ Left Ear?
9. Do you experience dizziness, imbalance, or vertigo? ☐ Yes ☐ No Comment _____
10. Do you have a family history of hearing loss? ☐ Yes ☐ No Comment _____
11. Do you have <u>any</u> history of exposure to loud noise, including when hearing protection was use? (ex. military, shooting, machines, music) ☐ Yes ☐ No Comment _____
12. Have you ever used hearing aids? ☐ Yes ☐ No Comment _____

GENERAL MEDICAL QUESTIONS

13. Have you ever had any of the following? ☐ Arthritis ☐ Cancer ☐ Dementia or Alzheimer's ☐ Depression ☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Head Injury ☐ Heart Disease ☐Hepatitis ☐ High Blood Pressure ☐ HIV ☐ Kidney Disease ☐ Migraines ☐ Multiple Sclerosis ☐ Pacemaker ☐ Parkinson's ☐ Seizures ☐ Stroke ☐ Thyroid Problems ☐ Vision Problems
14. Do you have any other current or past medical conditions? _____
15. Have you ever used tobacco products? ☐ Yes ☐ No Do you currently use tobacco products? ☐ Yes ☐ No
16. What medications (prescription, over-the-counter, herbal, supplement) do you currently take and what is the reason it is taken?
    - _____
    - _____
    - _____
    - _____
    - _____
    - _____
    - _____
    - _____
17. Is there anything else you would like us to understand about your hearing or your health? _____
    _____

I certify that the information on this form is correct to the best of my knowledge. I will not hold my audiologist or staff members responsible for errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient / Legal Guardian / Power of Attorney **Date**

REV. 12/17