Hearing Systems

ADULT MEDICAL HISTORY

1. Chief complaint: □Hearing Loss (□Left Ear/□Right Ear) □Tinnitus/Ringing □Dizziness
   □Difficulty Hearing (□In Quiet □In Noise □Telephone -- □Right Ear □Left Ear)
2. Have you ever had your hearing tested? □Yes □No
   If yes, please give date: _____ By Whom? _____
3. Have you ever had surgery that may have affected your hearing? □Yes □No
   If yes, what type? _____ By Whom? _____
4. Have you seen an Ear, Nose and Throat Physician (ENT)? □Yes □No
   If so, who did you see? _____ When? _____
5. Have you ever had an ear infection? □Yes □No (If yes, □as a child □as an adult)
6. Have you ever had a serious illness that may affect your hearing?
   □Yes □No (i.e., Scarlet Fever, Meningitis, Mumps, etc.)
7. Do you take medications every day? □Yes □No Briefly describe for what condition?
   _____
   Please supply a copy of a list of multiple medications you might be taking.
8. Do you take Aspirin or any blood thinner's? □Yes □No
   (If yes, name of medication _____ , How often do you take it? _____)
9. Do you have any other medical conditions that may affect your hearing? □Yes □No
   If yes, please briefly explain:
   _____
10. Is there a history of hearing loss in your family? □Yes □No
    If so, who? _____
11. Please check any of the following that you currently have or have had in the past:
    □Arthritis □Heart Trouble □Measles □Parkinson's □Asthma □Hepatitis
    □Meningitis □Bell's Palsy □High Blood Pressure □Sinusitis □Diabetes
    □Visual Trouble-Loss/Sight □Neurological Symptoms □Head Injury □HIV
12. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?
    □Yes □No If yes, please describe: _____
13. Have you seen a doctor for wax removal? □Yes □No
14. Do you have drainage of the ear? □Yes □No
15. Are you experiencing pain in your ear? □Yes □No
16. Do you think your hearing is changing? □Yes □No (□Gradual □Sudden)
17. Is this problem due to a work-related injury/exposure? □ Yes □No
18. How long have you had difficulty in communicating? _____
19. Have you ever been exposed to loud noise, either recently or in the past? (i.e., farm equipment, power tools, lawn mowers, chain saws, fire arms, military, etc.) □Yes □No
    If yes, was hearing protection used? □Yes □No or □Sometimes
20. Do you now or have ever worn hearing aids? □Yes □No
    Which ear is/was aided? □Right □Left
    Type of hearing aid? _____
    How long have you used a hearing aid? _____
    What would improve your current hearing aid? _____
21. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
    _____Improve hearing in quiet environments _____improve hearing in noisy environments
    _____Cosmetic appearance _____ Expense