Hearing and Medical History

Contact

Date (MM/DD/YYYY)

PATIENT INFORMATION

Name

First MI Last

Date of Birth

MM/DD/YYYY

ABOUT YOUR HEARING AND MEDICAL HISTORY

When was your last hearing test? Never had my hearing tested

Do you experience hearing loss? Yes No Not sure

If you experience hearing loss, please describe it:

If yes, which ear(s)? Right Left

How was the onset of your hearing loss Gradual Fluctuating Sudden Congenital Longstanding

Which ear do you use to talk on the phone? Right Left

Do you have a history of hearing aid use? Yes No

If yes, please describe:

Please check all that apply:

Dizziness Which best describes it? Constant Single episode Intermittent Lightheadedness

Accompanied by Hearing Loss Limb weakness Double vision Tingling

Tinnitus/ringing/noises Right Ear Left Ear

Ear fullness/pressure Right Ear Left Ear

Imbalance Describe:

Have you experienced any of the following medical conditions?

Diabetes	Heart problems	Vascular problems	High blood pressure
Cancer	Strokes	AIDS/HIV	Head injury
Autoimmune disease	Genetic disorder	Recent hospitalization	Macular degeneration
Mumps	Measles	Von Recklinghausen NF	Limb tingling/numbness
Encephalitis	Meningitis	Allergies	Changes in cognition
Paget's disease	Double vision	Malaria	Numbness around face

Please list all allergies (food, medication, plastics etc.):

ABOUT YOUR CURRENT MEDICATION

Please list all medication:

Date prescribed	Medication	Dose	Frequency

Do you take blood thinners? Yes No

Do you use a pacemaker? Yes No

Patient signature:

Please sign using mouse or finger on touch screen