Patient History Information

Name_____

MEDICAL HISTORY

☐ Yes ☐ No Have you seen a doctor in the past six months regarding your ears or hearing?
☐ Yes ☐ No Have you ever had your hearing tested?
If yes, when_____by whom_____
☐ Yes ☐ No Have you ever had any type of ear surgery?
If yes, type of surgery_____
☐ Yes ☐ No Do you take medicine every day?
For what condition_____
☐ Yes ☐ No Do you have any other medical conditions that might be related to your ears or hearing?
If yes, explain_____

ABOUT YOUR EARS:

Do you have any of these symptoms?

☐ Yes ☐ No Deformity of the ear
☐ Yes ☐ No Drainage from the ear
☐ Yes ☐ No Sudden or rapid loss of hearing in the past 90 days
☐ Yes ☐ No Acute or chronic dizziness
☐ Yes ☐ No Ringing in the ears
☐ Yes ☐ No Chronic ear infections
☐ Yes ☐ No Have you ever seen a doctor for wax removal?
☐ Yes ☐ No Do you ever have pain in your ears?
☐ Yes ☐ No Is there a concern of Speech and Language delay? (for child)
Which is your poorer ear? Same ◉ Right ○ Left ○

ABOUT YOUR HEARING:

Do you experience difficulty with the following?

☐ Yes ☐ No Understanding conversation
☐ Yes ☐ No Hearing in a crowd
☐ Yes ☐ No Hearing by telephone
☐ Yes ☐ No Hearing television
☐ Yes ☐ No Does anyone else in your family have a hearing problem?
What relationship?_____
☐ Yes ☐ No Do you now or have you ever worn a hearing aid?
If yes, how long ago was it purchased_____
How long have you had a hearing problem?_____

Who referred you to us?_____

Signature_____ Date_____