PATIENT HISTORY

Patient Name: _____ Date of Birth: _____ Date: _____

1. In which ear(s) are you having difficulty hearing? ☐ RIGHT ☐ LEFT ☐ BOTH ☐ NEITHER
2. Is one ear better than the other? ☐ YES ☐ NO
3. Which is your better ear? ☐ RIGHT ☐ LEFT
4. How long have you had this problem? _____
5. When was your last hearing test? _____
6. Do you currently wear a hearing aid? ☐ RIGHT ☐ LEFT ☐ BOTH ☐ NEITHER
7. How long have you worn hearing aids?
8. Do you have ringing, buzzing, or other sounds in your ears? ☐ RIGHT ☐ LEFT ☐ NEITHER
9. Is the ringing in your ears: ☐ CONSTANT ☐ OCCASIONAL
10. Does the ringing in your ears follow your heartbeat? ☐ YES ☐ NO
11. Do you have pressure in your ear(s)? ☐ RIGHT ☐ LEFT ☐ BOTH ☐ NEITHER
12. Do you have a family history of hearing loss? ☐ YES ☐ NO Who? _____
13. Have you had any recent ear infections? ☐ YES ☐ NO
14. Do you have arthritis or dexterity problems? ☐ HANDS ☐ ARMS ☐ SHOULDERS
15. Have you ever had wax removed from your ear(s)? ☐ YES ☐ NO
16. Have you ever had ear surgery? (please describe) ☐ YES ☐ NO _____
17. Have you been exposed to excessive noise? (please describe) ☐ YES ☐ NO _____
18. Do you experience hypersensitivity to loud sounds? ☐ YES ☐ NO
19. Are you ever dizzy? ☐ YES ☐ NO
20. How often do you feel dizzy? _____
21. How long do your dizzy episodes last? _____
22. Do you feel a sense of disequilibrium or a spinning sensation? _____
23. Do you have vision problems? (please describe) _____
24. What are your top three listening difficulties?

1. _____
2. _____
3. _____

General Health: (please mark if you have ever experienced)

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Allergies
- ☐ Thyroid issues
- ☐ Head trauma
- ☐ Stroke
- ☐ Diabetes
- ☐ Cancer
- ☐ Chemotherapy

Type: _____

Date of diagnosis: _____