MEDICAL HISTORY

Patient Name: _____

1. Chief complaint: ☐ Hearing Loss (☐ Right ear / ☐ Left ear / ☐ Both) ☐ Tinnitus / Ringing ☐ Dizziness
   ☐ Difficulty hearing (☐ in Quiet ☐ in Noise)

2. How long have you noticed this difficulty? _____

3. Do you think your hearing is changing? ☐ Yes ☐ No (☐ Gradual ☐ Sudden)

4. Have you ever been exposed to loud noise, either recently or in the past? ☐ Yes ☐ No
   If so, please mark all that apply:
   ☐ Farm Machinery ☐ Music ☐ Hunting / Shooting ☐ Factory Noise
   ☐ Power Tools ☐ Military ☐ Jet Engines ☐ Other _____

5. Do you have any of the following symptoms?
   ☐ Deformity of the ear ☐ Sudden or rapid loss within the past 90 days ☐ Tinnitus (ringing)
   ☐ Drainage of the ear ☐ Acute or chronic dizziness/imbalance ☐ Ear pain

6. Have you ever had your hearing tested? ☐ Yes ☐ No If so, when was your last test? _____

7. Have you ever had surgery that may have affected your hearing? ☐ Yes ☐ No Type? _____

8. Who is your primary physician? _____

9. Have you ever had an ear infection? ☐ Yes ☐ No (If yes, ☐ as a Child ☐ as an Adult)

10. Do you take any prescription medications on a regular basis? Please list:

    Medication _____ For _____

    Medication _____ For _____

    Medication _____ For _____

    Medication _____ For _____

    Medication _____ For _____

11. Please check any of the following that you currently have or have had in the past:

☐ Arthritis	☐ Heart Trouble / Attack	☐ Mastoid Surgery	☐ Parkinson's
☐ Asthma	☐ Hepatitis	☐ Mastoiditis	☐ Respiratory problems at birth
☐ Bell's Palsy	☐ High Blood Pressure	☐ Measles	☐ Rubella
☐ Chemotherapy	☐ HIV	☐ Meniere's	☐ Scarlet Fever
☐ Cholesteatoma	☐ Illness with High Fever	☐ Meningitis	☐ Sinusitis
☐ Craniofacial Anomalies	☐ Jaundice	☐ Mumps	☐ Stroke / TIA
☐ Cytomegalovirus at Birth (CMV)	☐ Kidney Disorders	☐ Neurological Symptoms	
☐ Diabetes	☐ Low Birth Weight	☐ Otosclerosis	☐ Visual Trouble - Loss/Sight
☐ Head Injury	☐ Malaria	☐ Ototoxicity	

12. Is there a history of hearing loss in your family? ☐ Yes ☐ No If so, who? _____

13. Is there a close friend / family member who you are concerned about their hearing health? _____
    If so, please tell us who this person is _____

14. If you are currently using a hearing aid, or have in the past, please answer the following:
    Which ear is / was aided? ☐ Right ☐ Left ☐ Both
    How long have you used a hearing aid? _____