

## PATIENT MEDICAL HISTORY FORM

PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

Chief Complaint:

- ☐ Hearing Loss (Right Ear/Left Ear)      ☐ Dizziness      ☐ Telephone (Right Ear/Left Ear)  
☐ Tinnitus/Ringing      ☐ Difficulty Hearing (In Quiet/In Noise)

How long have you noticed this difficulty? \_\_\_\_\_

Is this problem due to a work-related injury/exposure? ☐ Yes ☐ No

Do you feel your hearing is changing? ☐ Yes ☐ No (☐ Gradual ☐ Sudden)

Have you been exposed to loud noise, either recently or in the past? ☐ Yes ☐ No

If so, please mark all that apply:

- ☐ Farm Machinery      ☐ Factory Noise      ☐ Jet Engines  
☐ Music      ☐ Power Tools      ☐ Other: \_\_\_\_\_  
☐ Hunting/Shooting      ☐ Military

Have you seen an ear, nose and throat physician? ☐ Yes ☐ No

If so, who did you see? \_\_\_\_\_ When? \_\_\_\_\_

Have you had surgery that may have affected your hearing? ☐ Yes ☐ No

Is there a history of hearing loss in your family? ☐ Yes ☐ No

If so, who? \_\_\_\_\_

Have you ever had an ear infection? ☐ Yes ☐ No

If yes, ☐ as a child ☐ as an adult

In the past 10 years, have you experienced chronic or acute dizziness, lightheadedness or vertigo? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_

Do you take blood thinners? ☐ Yes ☐ No

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Parkinson's                  |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Scarlet Fever                |
| <input type="checkbox"/> Bell's Palsy  | <input type="checkbox"/> Malaria               | <input type="checkbox"/> Sinusitis                    |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Measles               | <input type="checkbox"/> Stroke/TIA                   |
| <input type="checkbox"/> Head Injury   | <input type="checkbox"/> Meningitis            | <input type="checkbox"/> Visual Trouble-Loss of Sight |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Mumps                 |   |
| <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Neurological Symptoms |   |

Please rank the following in order of importance (1=Very Important, 4=Not That Important) if a hearing aid is recommended for you:

1   2   3   4      Improved Hearing In Quiet

1   2   3   4      Improved Hearing In Noise

1   2   3   4      Cosmetic Appearance

1   2   3   4      Expense

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? \_\_\_\_\_

What would improve your current hearing aid? \_\_\_\_\_