Patient History Form

Name_____ Date_____

1. Chief Complaint(s): *Check all that apply*

   ____ Hearing Loss (right ear, left ear, or both)

   ____Tinnitus/Ringing in ears (right ear, left ear, or both) Describe the sound _____

   ____Dizziness/ Lightheadedness

2. Do family members complain that you do *not* hear well? _____Yes _____No
3. Out of which ear do you hear more clearly? _____right ear _____left ear
4. Have you ever worn a hearing aid? _____ Yes _____ No
5. Have you been exposed to any loud noise? _____Yes _____ No
6. Have you ever seen an ear, nose, and throat (ENT) physician? _____Yes _____No

   If yes, whom did you see? _____
7. Have you ever had ear surgery? _____ Yes _____ No

   If yes, when did this occur? _____
8. Is there a history of hearing loss in your family? _____ Yes _____No
9. Have you ever had an ear infection? _____ Yes _____No

   If yes, as a child_____ or as an adult_____
10. Have you ever experienced any head injury? _____Yes _____No

    If yes, when did this occur? _____
11. Please list any medications you are currently taking, *or* provide a copy of medications

_____

12. Have you ever had a serious illness which affected your hearing? _____Yes _____ No
13. Have you ever had a hearing test completed? _____Yes _____No

    If yes, when was the date of this test? _____
14. Do you have difficulty hearing the television? _____Yes _____No
15. Do you have difficulty hearing on the telephone? _____Yes _____No

    If yes, which ear do you use on the phone? _____right ear _____left ear
16. What questions or concerns would you like to have answered today?

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17. Do you have a **pacemaker** or **defibrillator**? Please *circle* which one you have.