Hearing Specialty Center, LLC

Hearing Health History

Patient Name _____ DOB _____ Date _____

Primary Symptom(s) _____

_____

Present Symptoms and Hearing Concerns:

Hearing Loss ☐ Right ☐ Left ☐ Both Ears ☐ N/A

When did your hearing loss begin? _____

Has your hearing changed? (e.g., sudden, gradual, fluctuating?) _____

Do you hear better out of one ear? _____ If so, which ear? _____

Do you know the cause of your hearing loss? _____

In the past 90 days have you experienced:

Ear pain ☐ Right ☐ Left ☐ Both Ears ☐ N/A

Ear discharge or drainage ☐ Right ☐ Left ☐ Both Ears ☐ N/A

Sudden change in hearing ☐ Right ☐ Left ☐ Both Ears ☐ N/A

Tinnitus (Noise in ears) ☐ Right ☐ Left ☐ Both Ears ☐ N/A

What does it sound like? _____

Is the sound constant or intermittent? _____

Is the sound distressing to you? (please describe) _____

Fullness/Pressure in Ears ☐ Right ☐ Left ☐ Both Ears ☐ N/A

When did the fullness first begin? _____

Is it constant or intermittent? _____

Dizziness/Unsteadiness ☐ Yes ☐ No

Describe dizziness/unsteadiness _____

When did it first occur? _____

Is it constant or intermittent? _____

How long does it last? _____

Do you have nausea or vomiting associated with it? _____

Ear Infections ☐ Right ☐ Left ☐ Both Ears ☐ N/A

Please describe condition _____

Previous treatments? _____

Have you seen a physician or ear specialist in the last six months? ☐ Yes ☐ No

Doctor's Name _____

Have you ever had any of the following conditions? (check all that apply)

☐ Ear surgery	☐ Skin tags on or near the ear	☐ Other ear malformations	☐ HIV
☐ Vision loss	☐ Eye surgery	☐ Cleft palate	
☐ Heart defect	☐ Learning impairment	☐ Diabetes	
☐ Arthritis	☐ Memory loss	☐ High blood pressure	
☐ Head injury	☐ Allergies	☐ Cancer	

Do you smoke? ☐ Yes ☐ No

Do you have a family history of hearing loss? ☐ Yes ☐ No

Relation to you _____

Noise History

Have you ever been exposed to loud noise? ☐ Yes ☐ No

If so, when ☐ military service ☐ work ☐ recreation ☐ other _____

Do you wear hearing protection in the presence of loud sounds? ☐ Yes ☐ No

Social History

Do you avoid social situations because you have difficulty hearing? ☐ Yes ☐ No

Do you find that you have to ask people to repeat themselves? ☐ Yes ☐ No

Do you sometimes hear words but do not understand them? ☐ Yes ☐ No

Do you have difficulty understanding people in noisy places? ☐ Yes ☐ No

Have you been told that you speak loudly? ☐ Yes ☐ No

Do others complain that you have the TV turned up too loud? ☐ Yes ☐ No

Do you find loud sounds bothersome? ☐ Yes ☐ No

Please describe your primary area of hearing difficulty _____

_____

_____

_____

_____

What best describes your hearing lifestyle? (check all the apply)

☐ Open/Reverberant Home	☐ Cell Phones	☐ Outdoor Activities
☐ Home Telephone	☐ Shopping	☐ Busy Restaurants
☐ Driving	☐ Movie Theaters	☐ Frequent Social Gatherings
☐ Religious Services	☐ Health Clubs	☐ Conference Calls
☐ Adult Conversations	☐ Small Group Meetings	☐ Travel & Airports
☐ Small Family Gatherings	☐ Conversations with Children	☐ Concerts & Arts
☐ Quiet Restaurants	☐ Television	☐ Entertainment Venues (Casinos, Exhibit Halls, etc.)