Hearing Systems

# ADULT MEDICAL HISTORY

1. Chief complaint: ☐ Hearing Loss (☐ Left Ear ☐ Right Ear) ☐ Tinnitus/Ringing ☐ Dizziness
   ☐ Difficulty Hearing (☐ In Quiet ☐ In Noise ☐ On the Telephone ☐ Right Ear ☐ Left Ear)
2. Have you ever had your hearing tested? ☐ Yes ☐ No
   If yes, please give date: _____ By whom? _____
3. Have you ever had surgery that may have affected your hearing? ☐ Yes ☐ No
   If yes, what type? _____ By whom? _____
4. Have you seen an ear, nose and throat physician (ENT)? ☐ Yes ☐ No
   If so, who did you see? _____ When? _____
5. Have you ever had an ear infection? ☐ Yes ☐ No If yes, ☐ as a child ☐ as an adult
6. Have you ever had a serious illness that may affect your hearing? (e.g. Scarlet Fever, Meningitis, Mumps, etc.) ☐ Yes ☐ No
7. Do you take medications every day? ☐ Yes ☐ No
   Briefly describe for what condition? _____ *Please supply a list of medications you might be taking.
8. Do you take Aspirin or any blood thinners? ☐ Yes ☐ No If yes, name of medication: _____ How often do you take it? _
9. Do you have any other medical conditions that may affect your hearing? ☐ Yes ☐ No
   If yes, please briefly explain: _____
10. Is there a history of hearing loss in your family? ☐ Yes ☐ No If so, whom? _____
11. Please check any of the following that you currently have or have had in the past:
    ☐ Arthritis ☐ Heart Problems ☐ Measles ☐ Parkinson's ☐ Asthma ☐ Hepatitis
    ☐ Meningitis ☐ Bell's Palsy ☐ High Blood Pressure ☐ Sinusitis ☐ Diabetes
    ☐ Visual Trouble ☐ Neurological Symptoms ☐ Head Injury ☐ HIV
12. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness or vertigo?
    ☐ Yes ☐ No If yes, please describe: _____
13. Have you seen a doctor for wax removal? ☐ Yes ☐ No
14. Do you have drainage of the ear? ☐ Yes ☐ No
15. Are you experiencing pain in your ear? ☐ Yes ☐ No
16. Do you think your hearing is changing? ☐ Yes ☐ No (☐ Gradual ☐ Sudden)
17. Is this problem due to a work-related injury/exposure? ☐ Yes ☐ No
18. How long have you had difficulty in communicating? _____
19. Have you ever been exposed too loud noise, either recently or in the past? (e.g. farm equipment,
    power tools, lawn mowers, chain saws, fire arms, military, etc.) ☐ Yes ☐ No
    If yes, was hearing protection used? ☐ Yes ☐ No ☐ Sometimes
20. Do you now or have ever worn hearing aids? ☐ Yes ☐ No
    Which ear is/was aided? ☐ Right ☐ Left ☐ Both
    Type of hearing aid? _____
    How long have you used a hearing aid? _____
    What would improve about your current hearing aid? _____
21. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
    ___ Improve hearing in quiet environments ___ Improve hearing in noisy environments
    ___ Cosmetic appearance ___ Expense

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