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| --- | --- |
| Reason for today's visit:(required) |   |

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| 10. Referred By: |  |

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| --- | --- |
| 11. Have you had any of the following conditions? If YES, briefly explain. |  |

 |
| Kidney Disease |
| Diabetes |
| Cancer |
| Hypertension |
| High Cholesterol |
| Visual Problems |
| Sinus Problem |
| Heart Disease |
| Seasonal Allergies |
| Other |
| Additional Comments: |
|

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| --- | --- |
| 12. List all medications you are currently taking: |  |

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| --- | --- |
| 13. Have you ever experienced head trauma? If YES, briefly explain. |  |

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|  |
| --- |
| Yes |
| No |

 |
| Additional Comments: |
|  |
|

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| --- | --- |
| 14. Have you ever had surgery on your ear(s), nose, throat, neck or, head? If YES, briefly explain.(required) |   |

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|  |
| --- |
| Yes |
| No |

 |
| Additional Comments: |
|  |
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| --- | --- |
| 15. When did you first notice your hearing problem? |  |

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| --- | --- |
| 16. Was your change in hearing SUDDEN or GRADUAL?(required) |   |

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|  |
| --- |
| Sudden |
| Gradual |

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| --- | --- |
| 17. Has your hearing become worse since you first noticed the problem?(required) |   |

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| --- |
| Yes |
| No |

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| --- | --- |
| 18. Do you hear better in one ear than the other?(required) |   |

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|  |
| --- |
| Yes, Right ear is better |
| Yes, Left ear is better |
| No |

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| --- | --- |
| 19. Does your hearing REMAIN CONSTANT or FLUCTUATE?(required) |   |

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|  |
| --- |
| Remains Constant |
| Fluctuates |

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|  |  |
| --- | --- |
| 20. Have you experienced any ear pain?(required) |   |

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|

|  |
| --- |
| Yes, Both Ears |
| Yes, Left Ear Only |
| Yes, Right Ear Only |
| No |

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|  |
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| --- | --- |
| 21. Have you experienced plugged ear(s)?(required) |   |

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|  |
| --- |
| Yes, Both Ears |
| Yes, Right Ear Only |
| Yes, Left Ear Only |
| No |

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| --- | --- |
| 22. Have you experienced any ringing/buzzing?(required) |   |

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|  |
| --- |
| Yes, Both Ears |
| Yes, Right Ear Only |
| Yes, Left Ear Only |
| No |

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| Additional Comments: |
|  |
|

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| --- | --- |
| 23. Have you experienced any dizziness/vertigo? If YES, briefly explain.(required) |   |

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| --- |
| Yes |
| No |

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| Additional Comments: |
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| --- | --- |
| 24. Have you ever been exposed to loud noise (work, recreation, Military service)? If Yes, briefly explain.(required) |   |

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| --- |
| Yes |
| No |

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| Additional Comments: |
|  |
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| --- | --- |
| 25. Has anyone in your family experienced hearing loss? If YES, who?(required) |   |

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| --- |
| Yes |
| No |
| Unknown |

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| Additional Comments: |
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| --- | --- |
| 26. Which situations do you have difficulty hearing? |  |

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| --- | --- |
| 27. Have you had your hearing tested before? If Yes, briefly explain.(required) |   |

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| --- |
| Yes |
| No |

 |
| Additional Comments: |
|  |
|

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| --- | --- |
| 28. Have you ever worn hearing instruments? If Yes, briefly describe.(required) |   |

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|  |
| --- |
| Yes - Currently |
| Yes - In The Past |
| No |

 |
| Additional Comments: |
|  |
|

|  |  |
| --- | --- |
| 29. Do you smoke? |  |

 |
| Yes |
| No |