|  |  |  |
| --- | --- | --- |
| |  |  | | --- | --- | | Reason for today's visit:(required) |  | |
|  |
|  |
| |  |  | | --- | --- | | 10. Referred By: |  | |
|  |
|  |
| |  |  | | --- | --- | | 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: |
| |  |  | | --- | --- | | 12. List all medications you are currently taking: |  | |
|  |
|  |
| |  |  | | --- | --- | | 13. Have you ever experienced head trauma? If YES, briefly explain. |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 14. Have you ever had surgery on your ear(s), nose, throat, neck or, head? If YES, briefly explain.(required) |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 15. When did you first notice your hearing problem? |  | |
|  |
|  |
| |  |  | | --- | --- | | 16. Was your change in hearing SUDDEN or GRADUAL?(required) |  | |
| |  | | --- | | Sudden | | Gradual | |
|  |
| |  |  | | --- | --- | | 17. Has your hearing become worse since you first noticed the problem?(required) |  | |
| |  | | --- | | Yes | | No | |
|  |
| |  |  | | --- | --- | | 18. Do you hear better in one ear than the other?(required) |  | |
| |  | | --- | | Yes, Right ear is better | | Yes, Left ear is better | | No | |
|  |
| |  |  | | --- | --- | | 19. Does your hearing REMAIN CONSTANT or FLUCTUATE?(required) |  | |
| |  | | --- | | Remains Constant | | Fluctuates | |
|  |
| |  |  | | --- | --- | | 20. Have you experienced any ear pain?(required) |  | |
| |  | | --- | | Yes, Both Ears | | Yes, Left Ear Only | | Yes, Right Ear Only | | No | |
|  |
| |  |  | | --- | --- | | 21. Have you experienced plugged ear(s)?(required) |  | |
| |  | | --- | | Yes, Both Ears | | Yes, Right Ear Only | | Yes, Left Ear Only | | No | |
|  |
| |  |  | | --- | --- | | 22. Have you experienced any ringing/buzzing?(required) |  | |
| |  | | --- | | Yes, Both Ears | | Yes, Right Ear Only | | Yes, Left Ear Only | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 23. Have you experienced any dizziness/vertigo? If YES, briefly explain.(required) |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 24. Have you ever been exposed to loud noise (work, recreation, Military service)? If Yes, briefly explain.(required) |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 25. Has anyone in your family experienced hearing loss? If YES, who?(required) |  | |
| |  | | --- | | Yes | | No | | Unknown | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 26. Which situations do you have difficulty hearing? |  | |
|  |
|  |
| |  |  | | --- | --- | | 27. Have you had your hearing tested before? If Yes, briefly explain.(required) |  | |
| |  | | --- | | Yes | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 28. Have you ever worn hearing instruments? If Yes, briefly describe.(required) |  | |
| |  | | --- | | Yes - Currently | | Yes - In The Past | | No | |
| Additional Comments: |
|  |
| |  |  | | --- | --- | | 29. Do you smoke? |  | |
| Yes |
| No |