

Patient Name: _____

Date: _____

1. Chief concern: Hearing Loss (Right ear/ Left ear/ Both) Tinnitus/Ringing
 Dizziness Difficulty hearing (in Quiet in Noise)
 Telephone Hearing aids Other: _____
2. Have you ever been exposed to loud noise, either recently or in the past? Yes No
If so, please mark all that apply:
 Farm Machinery Music Hunting/Shooting Factory Noise
 Power Tools Military Jet Engines Other:
3. Do you have any of the following symptoms?
 Deformity of the ear Drainage of the ear Tinnitus (ringing) Ear pain
 Sudden or rapid loss within the past 90 day's Acute or chronic dizziness/Imbalance
4. Have you ever had your hearing tested? Yes No
5. Have you seen an Ear, Nose and Throat Physician? Yes No
6. Have you ever had surgery that may have affected your hearing? Yes No
7. Is there a history of hearing loss in your family? Yes No
8. Have you ever had an ear infection? Yes No (If yes, as a child as an adult)
9. Please check any of the following that you currently have or have had in the past:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Measles	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Chemo/Radiation	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Bell's palsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mumps	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV	<input type="checkbox"/> Neurological	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Malaria	<input type="checkbox"/> M.S	<input type="checkbox"/> Vision Trouble
10. Are you currently taking a blood thinner? Yes No
11. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:

_____ Improved hearing in quiet	_____ Improved hearing in noise
_____ Cosmetic appearance	_____ Expense
12. If you are currently using a hearing aid, or have in the past, please answer the following:
Which ear is/was aided? Right Left Both
How long have you used a hearing aid? _____