

Patient History Form

Patient Name: _____ DOB: _____ Date: _____

Primary Concerns: _____

How or when did your problem first occur? _____

Have any of these concerns been previously evaluated? _____

• **Do you have any of the following symptoms? *Please indicate which ear.***

- | | | | |
|--|----------|-----------|------|
| <input type="checkbox"/> Difficulty Hearing | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Hearing Loss Has Progressed Gradually | | | |
| <input type="checkbox"/> Hearing Loss Began Suddenly | | | |
| <input type="checkbox"/> My hearing fluctuates from time to time | | | |
| <input type="checkbox"/> Ear Pain | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Drainage | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Fullness / Pressure | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Tinnitus (Ringing / Noise in your head/ears) | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Dizziness / Off Balance | | | |
| <input type="checkbox"/> Vertigo (Is there a sensation of the room spinning) | | | |

• **Please indicate any of the following, that you currently have or have had in the past:**

- | | | |
|--|--|--|
| <input type="checkbox"/> Vision Loss | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Meniere’s Disease |
| <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> CMV | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson’s Disease | <input type="checkbox"/> Measles and Mumps |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Tingling / Numbness in Face | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Exposure to Loud Noise | |

Family History of Hearing Loss: Who? _____

Head Injury? Date and symptoms: _____

Bell’s Palsy: Affected Side: _____

Stroke / TIA: Affected Side: _____

Neurological Disorder: _____

Ear Trauma / Surgery: Ear - Right / Left Type: _____

MRI / CT of Head? Date: _____ Location: _____

• **Please list all current medications you routinely take, both prescription and over the counter.**

Medication

Purpose

Patient History Form

This short questionnaire is designed to find out what sort of effects your hearing has on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer ALL questions by circling the number that best reflects how your hearing affects you.

	(least important)			(most important)	
1) How important is hearing in small groups?	1	2	3	4	5
2) How important is hearing better in large gatherings?	1	2	3	4	5
3) How important is hearing your family (spouse / children / grandchildren)?	1	2	3	4	5

	(Rarely)			(Often)	
4) How often does it sound as if people are mumbling?	1	2	3	4	5
5) Does your hearing frustrate you?	1	2	3	4	5
6) Does your hearing frustrate your loved ones?	1	2	3	4	5

7) How long have you had trouble hearing?	1-2 Years	3-5 Years	6-8 Years	8-10 Years	10+ Years
---	--------------	--------------	--------------	---------------	--------------

How important is it for you to improve your hearing? 0-----3-----5-----7-----10

How ready are you to improve your hearing? 0-----3-----5-----7-----10

Please indicate ALL areas where you find it difficult to communicate or often ask individuals to repeat what was said.

- Communicating 1 on 1
- Communicating with children (Grandchildren)
- Environments with **Mild** Background Noise
- Environments with **Moderate** Background Noise
- Environments with **Excessive** Background Noise
- Meetings / At Work
- Large Social Gatherings
- Quiet Environments
- Church
- Live Theatre / Auditoriums
- Outdoor Activities
- With Your Partner
- Small Groups
- Telephone
- Restaurants
- Movie Theatre
- Sporting Events
- In the Car
- Television

Please list 3 areas of communication that are most important for you to improve:

Example: I want to hear the television better.

1) _____

2) _____

3) _____