KAW VALLEY HEARING

Lawrence, KS
Bonner Springs, KS
Leavenworth, KS
www.kawvalleyhearing.com

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.***

☐	Difficulty Hearing	Left Ear	Right Ear	Both
	☐Hearing Loss Has Progressed Gradually			
	☐Hearing Loss Began Suddenly			
	☐My hearing fluctuates from time to time			
☐	Ear Pain	Left Ear	Right Ear	Both
☐	Ear Drainage	Left Ear	Right Ear	Both
☐	Ear Fullness / Pressure	Left Ear	Right Ear	Both
☐	Tinnitus (Ringing / Noise in your head/ears)	Left Ear	Right Ear	Both
☐	Dizziness / Off Balance			
☐	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:**

☐Vision Loss	☐Sinusitis	☐Meniere's Disease
☐Peripheral Neuropathy	☐CMV	☐Migraines
☐Diabetes	☐Multiple Sclerosis	☐Ear Infections
☐High Blood Pressure	☐Parkinson's Disease	☐Measles and Mumps
☐Heart Condition	☐Tingling / Numbness in Face	☐Hepatitis
☐Meningitis	☐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**
_____	_____
_____	_____
_____	_____
_____	_____

KAW VALLEY HEARING

Lawrence, KS
Bonner Springs, KS
Leavenworth, KS
www.kawvalleyhearing.com

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	☐ Small Groups
☐ Large Social Gatherings	☐ Telephone
☐ Quiet Environments	☐ Restaurants
☐ Church	☐ Movie Theatre
☐ Live Theatre / Auditoriums	☐ Sporting Events
☐ Outdoor Activities	☐ In the Car
☐ With Your Partner	☐ 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) _____

_____