

Confidential Patient History - Dated: _____

Patient Name _____ **Birth Date:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

MEDICAL HISTORY:

Yes No Have you seen a doctor in the past six months? (Dr. _____)

Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, give date _____

Yes No Have you ever had your hearing tested?
If yes, give date _____ by whom _____

Yes No Have you ever had any type of ear surgery?
If yes, type of surgery _____ (Dr. _____)

Yes No Do you take medicine every day?
For what condition? _____

Yes No Do you have any other medical conditions?
If yes, explain _____

Yes No Are you hypertensive?; Yes No Nervous?; Yes No Have a heart condition?

ABOUT YOUR EARS: Do you have any of these symptoms?

Yes No Deformity of the ear

Yes No Drainage from the ear

Yes No Sudden or rapid loss of hearing in the past 90 days

Yes No Acute or chronic dizziness

Yes No Which is your poorer ear? Same Right Left

Yes No Have you ever seen a doctor for wax removal?

Yes No Do you ever have pain in your ears?

ABOUT YOUR HEARING: Do you experience difficulty with the following?

Yes No Understanding conversation

Yes No Hearing in a crowd

Yes No Hearing by telephone

Yes No How long have you had a hearing problem? _____

Yes No Does anyone else in your family have a hearing problem?
What relationship? _____

Yes No Do you now or have you ever worn a hearing aid?
If yes, how do you think you may be helped? _____

Who referred you to us? _____

Signature _____ Date _____