Adult History Sheet

Name:_____ Age:_____ Date:_____

Reason for today's visit:_____

Have you ever had your hearing tested before? Yes No

If yes, when?_____ where?_____

Have you ever had surgery on ears, nose or throat? If yes, explain:_____ Yes No

_____

Do you have any history of noise exposure?, (factory, farm machinery, ammunition, chain saws, etc.) Yes No

If yes, explain:_____

Is there a family history of hearing loss at a young age? Yes No

Do you have tinnitus? (ringing in the ear) If yes, left ear___ right ear___ both___ Yes N0

Have you had any drainage from your ear in the past 90 days? Yes No

Have you had a sudden or rapidly progressive hearing loss? If yes, explain:_____ Yes No

_____

Do you have acute or chronic dizziness or vertigo? If yes, explain:_____ Yes No

_____

Do you have pain or discomfort in your ear(s)? If yes, explain:_____ Yes No

Have you had any of the following? Check all that apply:

___ Diabetes	___ Sinus Problems	___ Allergies	___ Parkinsons
___ Stroke	___ Neurological	___ Heart Condition	___ High Blood Pressure
___ Measles	___ Mumps	___ Scarlet Fever	___ Bell's Palsy
___ Head Trauma	___ Radiation	___ Chemotherapy	____ Tobacco User

Please list all medications (include dosage, how taken, frequency taken) IF YOU HAVE A LIST, PLEASE ASK THE RECEPTIONIST TO MAKE A PHOTOCOPY.

Circle All That Apply

Do you attend large meetings/family gatherings/social events? Very Often Often Occassionally Rarely Never

Do you have difficulty hearing in any of the following situations? Restaurant One on One Conversations

Telephone Television Meetings In a Crowd Movie Theater Other: Please Describe:_____

_____

_____

Do you currently use hearing aids? ____No If Yes: _____Left Ear _____Right Ear _____Both Ears

When did you purchase them?_____Where did you purchase them?:_____

Are you satisfied with your current hearing aids? For example, do they fit properly? Are you able to understand conversations? Explain which situations are difficult for you._____

_____