# Hearing Solutions

## Medical History Form

Patient Name: _____ Age: _____ Today's Date: _____

1. Reason for appointment?

| | | | |
|---|---|---|---|
| Hearing loss | _____ Right ear | _____ Left ear | _____ Both |
| Difficulty understanding speech | _____ In quiet | _____ In noise | _____ Both |
| Tinnitus or ringing in ears | _____ Right ear | _____ Left ear | _____ Both |

Dizziness _____ Yes _____ No How often? _____

2. How long have you noticed the problem? _____

_____ Gradual change _____ Past 90 days _____ Sudden change

3. Have you been exposed to loud noise, either recently or in the past (Check all that apply)?

| | |
|---|---|
| _____ Military | _____ Jet engines |
| _____ Power tools | _____ Workplace noise |
| _____ Music | _____ Farm machinery |
| _____ Gun fire | _____ Other: _____ |

4. Have you seen an Ear, Nose & Throat physician (ENT)? _____ Yes _____ No

5. Have you had any ear infections or ear surgery that affected your hearing? _____ Yes _____ No

   If yes, please explain: _____

6. Is there a history of hearing loss in your family? _____ Yes _____ No

   If yes, please explain: _____

7. Do you have a pacemaker? _____ Yes _____ No

8. Please list all medications including over-the-counter products (we can copy a prepared list if you have one.)

   _____

   _____

   _____

   _____

9. Please circle any of the following that you have experienced:

| | | | |
|---|---|---|---|
| Arthritis | Head Injury | Asthma | High blood pressure |
| Heart disease | Hepatitis | Sinusitis | Neurological symptoms |
| Stroke/TIA | Measles | Meningitis | Diabetes |
| Parkinson's | Bell's Palsy | HIV | Vision Loss |
| Cancer Type _____ | | Radiation | Chemotherapy |

10. If hearing aids are needed please rank the following in order of importance **(1 – 5 with 1 the most important, then 2, etc. )**

    _____ Improved hearing in quiet

    _____ Improved hearing in noise

    _____ Improved hearing at work

    _____ Cost

    _____ Cosmetic appearance

11. If you currently use hearing instruments, please answer the following:

    Which ear is aided? _____ Right _____ Left _____ Both

    How long have you worn the devices? _____

    Is there anything you would you like to improve about the current devices? _____

    _____

12. What is your goal for today's appointment? _____

    _____

13. Is there anything else related to your hearing that we should know?