**Patient History**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please **circle** the appropriate response for your history and describe as indicated.

1. Do you have difficulty hearing or understanding? No Yes

 If yes, is one ear worse than the other? No Yes ( Right / Left / Both)

 Was the onset: gradual sudden

2. Have you had a hearing test before? No Yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Do you have ringing in your ear(s)? No Yes ( Right / Left / Both)

4. Do you have a history of ear infections? No Yes

5. Have you noticed any pain, pressure or fullness in your ear(s)? No Yes (Right / Left / Both)

6. Do you experience dizziness? No Yes (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Do you have a history of noise exposure? No Yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you ever had ear surgery? No Yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Have you ever had a head or ear injury? No Yes, please describe \_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Does any member of your family have a hearing loss? No Yes, who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Have you ever worn hearing aids before? No Yes ( Right / Left / Both)

If yes, how long have you worn devices? \_\_\_\_\_ Months/\_\_\_\_\_Years

12. Have you ever taken chemotherapy medications? No Yes

13. Are you currently enrolled in hospice? No Yes

If yes, is this visit related to your hospice condition? No Yes

14. Please list any other medical conditions you are currently being treated by a physician for \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Audiologist Initials \_\_\_\_\_\_\_\_