Hearing Care Specialists, Inc.

PATIENT NAME:

Hearing History

1. What concern(s) bring you here today? Please circle all that apply.
   Hearing Loss Tinnitus/Ringing in ear(s) Dizziness Other_____
2. How long have you noticed this difficulty?_____ Has it gotten worse?_____
3. Do you have difficulty hearing when…

Listening one-on-one in a quiet setting?	YES	NO
In groups or noisy places?	YES	NO
While watching TV or movies?	YES	NO
At work?	YES	NO
In social/recreational situations?	YES	NO
Do you HEAR but not UNDERSTAND?	YES	NO

4. Which do you feel is your BETTER hearing ear? Right Ear Left Ear
5. Have you ever been exposed to loud noise, either recently or in the past? YES NO
6. The exposure was: Occupational Recreational
7. Please circle all that apply:

Machinery	Power Tools	Factory Noise
Military	Hunting/Shooting	Jet Engines
Music/Concerts	Other_____	

8. When exposed to noise, do you wear ear protection? YES NO
9. If yes, what type? Generic foam plugs Ear Muffs Custom Fit Plugs
10. Are you bothered by noises (Tinnitus) in your ears or head? YES NO
    In which ear is the Tinnitus? Right Ear Left Ear Both Ears
    The Tinnitus is: Constant Occasional
11. Do you ever have Dizziness/Vertigo? YES NO
    Is your Doctor aware of the dizziness/vertigo? YES NO
12. Is there a history of hearing loss in your family? YES NO Who?_____
13. Have you ever had your hearing tested? YES NO Date of last test?_____
14. If amplification is recommended for you, please rank the following in order of importance:

_____ Improved hearing in quiet	_____ Improved hearing in noise
_____ Cosmetic appearance	_____ Expense

Health History

1. Do you have any of the following symptoms? (Circle all that apply)
   Drainage of the ear Ear pain Sudden or rapid hearing loss within the past 90 days
2. Have you ever had surgery that may have affected your hearing? YES, Type?_____ NO
3. Do you have a history of ear infections? YES (as child as adult) NO
4. Please circle any of the following that you currently have or have had in the past:

Diabetes	Heart Disease	High Blood Pressure	Stroke/TIA
Dizziness/Vertigo	Balance Issues	Headaches	Head Injury
Measles	Mumps	Scarlet Fever	
Neurological Problems	Alzheimer's/Dementia	Parkinson's	
Cancer	Chemotherapy	Radiation	Other

5. Please list any prescription medications you take on a regular basis:
   Medication:_____ For:_____
   Medication:_____ For:_____
   Medication:_____ For:_____