Patient Name____ Today's Date _____________

Medical History

Reason for today's
appointment:____

Allergies to any medication, plastics, etc.____

Current medications:
____
____

Have you ever had ear surgery? ___ YES ___NO If yes which ear? _________________________

Describe: ____

Please list all major illness/major surgeries in the past 10 years:
____
____

Are you diabetic? ___ YES ___NO

Hearing History

When was your last hearing exam? _________________ By Whom? ____________________________

What were the recommendations? ____

How long ago did you notice difficulty hearing? __Recently __ 1-5 years __ 5-10 years __ Over 10 years

Have you ever used an assistive listening device? ____Left ____Right

Do you have a poorer ear? ___ YES ___NO Which ear? ____Left ____Right

Which ear do you use on the telephone? ____Left ____Right

Have you experienced a sudden or progressive hearing loss in the last 90 days? __Left ___Right __Both

Have you experienced any drainage from your ear(s) in the past 90 days? ____Left ____Right ____ Both

Do you suffer from pain or discomfort in your ears? ____Left ____Right ____ Both

Do you suffer from acute or chronic dizziness? ___ YES ___NO

Do you have tinnitus (ringing in the ears)? ___Right ___Left ___Both How Long? ________