Assured Audiology & Hearing Solutions

PATIENT HISTORY

Patient Name_____ DOB_____/_____/_____
Address _____

AUDIOLOGIC HISTORY

Yes No Have you ever had your hearing tested?
If yes, give date _____ by whom _____
Yes No Do you have ringing in your ears? (ringing, buzzing, hissing)
If yes, which ear? _____ How frequent?_____
Yes No Have you had a history of an ear disease/ear surgeries
If yes, give date _____ Reason _____
Yes No Have you ever had any type of ear surgery?
If yes, type of surgery _____ (Right Ear, Left Ear or Both)
Yes No Do you have a family history of hearing loss?
What relationship_____
Yes No Do you have history of chronic ear infections as a child or adult?
Yes No Any history of trauma to the head?
If so explain _____
Yes No Do you have a history of noise exposure?
If so explain _____
Yes No Do you ever experience dizziness, vertigo, or loss of balance?
If so explain _____
Yes No Do you ever have pain in your ears? (Otalgia)
Yes No Have you ever experienced any extreme sensitivity to sound?
Yes No Do you ever feel fullness in your ears?
Yes No Do you have sinus or allergy problems?
Yes No Do you know what caused your hearing loss?
If so explain _____

Hearing Aid History

Yes No I do not own a hearing aid; I am interested in finding out if one can help.
Yes No I do not own a hearing aid; I am not interested in getting a hearing aid at this time.
If yes explain _____
Yes No I own a hearing aid now but I do not use it.
If yes explain _____
Yes No I own a hearing aid now, but would like more information about new advances and technology.