

**MEDICAL HISTORY:**

Yes No Have you seen a doctor in the past six months? (Dr. \_\_\_\_\_)

Yes No Have you seen a doctor specializing in diseases of the ear?

If yes, give date \_\_\_\_\_

Yes No Have you ever had your hearing tested?

If yes, give date \_\_\_\_\_ by whom \_\_\_\_\_

Yes No Have you ever had any type of ear surgery?

If yes, type of surgery \_\_\_\_\_(Dr. \_\_\_\_\_)

Yes No Do you take medicine every day?

For what condition? \_\_\_\_\_

Yes No Do you have any other medical conditions?

If yes, explain \_\_\_\_\_

Yes No Are you hypertensive?; Yes No Nervous?; Yes No Have a heart condition?

**ABOUT YOUR EARS:** Do you have any of these symptoms?

Yes No Deformity of the ear

Yes No Drainage from the ear

Yes No Sudden or rapid loss of hearing in the past 90 days

Yes No Acute or chronic dizziness

Which is your poorer ear? Same Right Left

Yes No Have you ever seen a doctor for wax removal?

Yes No Do you ever have pain in your ears?

**ABOUT YOUR HEARING:** Do you experience difficulty with the following?

Yes No Understanding conversation

Yes No Hearing in a crowd

Yes No Hearing by telephone

How long have you had a hearing problem? \_\_\_\_\_

Yes No Does anyone else in your family have a hearing problem?

What relationship? \_\_\_\_\_

Yes No Do you now or have you ever worn a hearing aid?

If yes, how do you think you may be helped? \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_