Case History

Patient Name: _____ Date: _____

Chief Complaint

1. Chief complaint: (mark all that apply)
   Hearing Loss ☐ Cerumen/Wax ☐ Tinnitus/Ringing ☐
2. How did you learn about our practice?
3. How long have you noticed the above conditions(s)? _____
   What do you attribute it to? _____
4. How did this progress? Gradually ☐ Suddenly ☐
5. Why have you decided to have your hearing tested at this time (mark all that apply)
   Physician Referra ☐ Family/Friend Recommended ☐ Healthy Curiosity ☐
   Annual Evaluation ☐ I feel my hearing is poor and may need to be aided ☐

Hearing Health History

6. Have you ever been exposed to loud sounds, either recently or in the past? Yes ☐ No ☐

If so, mark all that apply:

Farm Equipment ☐ Music/iPod ☐ Work-Related Noise: _____
Hunting/Shooting ☐ Armed Forces ☐ Motorcycles ☐ Power tools ☐ Other: _____

7. Have you had any of the following? (mark all that apply)
   Deformity of the ear ☐ Drainage from ear ☐ Head Trauma ☐ Vertigo/Dizziness ☐ Ear pain ☐
8. Have you ever had your hearing tested? No ☐ Yes ☐ If so, when was your last test?
9. Is there a history of hearing loss in your family? No ☐ Yes ☐ If so, who? _____
10. Have you ever had an ear infection? No ☐ Yes ☐ If so, as a child ☐ as an adult ☐
11. Have you ever had ear-related surgery? No ☐ Yes ☐ If so, type, when, where? _____
12. Do you currently utilize hearing aids? No ☐ Yes ☐ If yes, when did you purchase them? _____
13. Do you have any complaints with your current aids? (explain) _____

Other Medical History

14. Please check any of the following that you currently have or have had in the past:

☐ Arthritis	☐ Heart Conditions	☐ Asthma	☐ Parkinson's Disease
☐ Hepatitis	☐ Sinusitis	☐ Meningitis	☐ Smoker (current/former)
☐ Diabetes (type____)	☐ Cancer	☐ HIV or AIDS	☐ Neurological disorder
☐ Measles	☐ Bell's Palsy	☐ Stroke/TIA	☐ Meniere's disease
☐ Malaria	☐ Vision loss	☐ Head Injury	☐ High blood pressure
☐ COVID	☐ Alzheimer's disease	☐ Dementia	☐ High cholesterol

_____ _____
Signature of Patient or Guardian Date