CASE HISTORY

Personal Information

Name___________________________ Date of Birth _______________ Age_____

Adress____

(city) (state) (zip)

Home Phone __________________ Work/Cell Phone____________________ Email___________________

Preferred method of contact **(circle one)** Home Phone Work/Cell Phone Email

Emergency Contact_____________________________ Phone Number _______________________

Marital Status: **(circle one)** Married Single Widow

Who may we thank for referring you? **(Circle one below or write name)** _________________________

Yellow Pages Gazette Friend/Relative Internet Television Facebook Other

Hearing History

When did you first notice you were having difficulty hearing or understanding? ______________________

How do you think you hear? **(circle one)** Good Fair Poor

Have you ever had your hearing tested before? _______ When? __________ Where? ________________

What were the finding/recommendations? ____

Has your hearing loss come upon gradually or suddenly? **(circle one)** Gradually Suddenly

If suddenly, within the previous 90 days? Yes No

Does your hearing seem to fluctuate? Yes No

Do you have any ringing or other noises in your ears? Yes No

Do you have any dizziness or off-balance sensations? Yes No

Does any other member of your family have a hearing loss? Yes No If yes, who? __________________

Do you have a history of exposure to noise? ______________________________

Have you had any earaches, infections or drainage from your ears recently? Yes No

If yes, please explain ____

Have you had any pain or discomfort in your ears recently? Yes No

Any medical treatment or surgery on your ears? Yes No

If yes, please explain ____

Have you had any pressure or fullness in your ears recently? Yes No

Do you have any allergies? Yes No If yes, please explain ______________________________________

Are you taking any medications/drugs? Yes No If yes, please explain ___________________________

Name of family physician/ENT: ____

Have you seen your doctor within the last six months? Yes No

Do you have insurance for hearing aids? Yes No

Would you like a copy of your test results sent to your physician? Yes No