Northern Hearing

Adult History Form

PATIENT NAME: _____

1) Have you had a hearing test before? (circle one) Yes No

   If yes, when and where? _____

2) Have you been previously diagnosed with hearing loss? Yes No

   If yes, please indicate ear: Right Left Both

3) Have you noticed a change in your hearing in the past year? Yes No

   If yes, was it gradual or sudden? _____

4) Do hear better out of one ear than the other? Yes No

   If yes, please indicate ear: Right Left

5) Do you experience problems involving dizziness? Yes No

   If yes, please fill out a Dizziness Questionnaire available at the front desk.

6) Do you experience "ringing" (tinnitus) in your ears? Yes No

   If yes, please indicate ear: Right Left Both

   Is it constant, frequent, occasional or seldom? _____

   Is it high pitch, low pitch or varies? _____

   Does anything seem to make it better or worse? Please explain: _____

   _____

   Please describe the sound you hear (ex. Buzzing, crackling, hissing, beeping, roaring, humming, etc): _____

   _____

7) Do you have any pressure or fullness in your ears? Yes No

   If yes, please indicate ear: Right Left Both

8) Do you have pain in your ears? Yes No

   If yes, please indicate ear: Right Left Both

9) Have you been evaluated by an ear specialist (ENT)? Yes No

   If yes, who did you see and when? _____

10) Do you have a history of ear infections? Yes No

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Adult History Form (cont.)

11) Do you have problems with frequent colds, allergies or sinuses? Yes No

12) Have you had any ear surgeries? Yes No

If yes, please explain: _____

_____

13) List any medications you are taking: _____

_____

14) Have you experienced any head injuries in the past five years? Yes No

If yes, please explain: _____

_____

15) Do you have any history of noise exposure? (circle all that apply)

Hunting Target Shooting Law Enforcement Machinery
Military Fireworks Woodworking Music
None Other: _____

16) Have you been diagnosed with any pre-existing conditions? (circle all that apply)

Cancer Diabetes Stroke Meniere's Disease
Parkinson's Otosclerosis Heart Disease Multiple Sclerosis
Kidney Failure High Blood Pressure None
Other: _____

17) Have you ever worn hearing aids? Yes No

18) Do you currently own hearing aids? Yes No

If yes: Make _____
Model _____
Year Purchased _____
Bought where? _____

19) Are you considering purchasing hearing aids? Yes No

20) Please list any other important information you feel we should know: _____

_____

_____

Signature _____ Date _____

(Please note: All information is completely confidential and available only per release of the patient)