

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Adult History**

What is your chief concern about your ears/hearing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suspect hearing loss in your right\_\_\_\_\_ left\_\_\_\_ both ears\_\_­\_\_ ? If so, for how long?\_\_\_\_\_\_

Do you have tinnitus (noise in your ears)?\_\_\_\_\_ If so please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the noise last more the 15 min?\_\_\_\_ Does it interfere with sleep or concentration?\_\_\_\_\_\_\_\_

Any type of tobacco use? \_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol? \_\_\_\_\_\_\_\_\_\_\_ Caffeine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your hearing suddenly changed?\_\_\_\_\_\_ If so, when or why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your hearing seem to fluctuate?\_\_\_\_\_ Is there a family history of hearing loss?\_\_\_\_\_\_\_\_\_

Have you had ear wax removed before? \_\_\_\_\_\_\_Do you have a history of ear aches? \_\_\_\_\_\_ infections? \_\_\_\_\_ discharge? \_\_\_\_\_Have you ever been treated by an ear doctor? \_\_\_\_\_\_ If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been exposed to noise through work or recreational activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear hearing protection? \_\_\_\_\_\_\_\_\_\_ If so, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please check all that apply.***

**I have difficulty hearing:**

In background noise \_\_\_\_\_ children \_\_\_\_\_ co-workers \_\_\_\_\_ spouse \_\_\_\_\_ radio/TV \_\_\_\_\_ on the telephone \_\_\_\_\_ at religious services \_\_\_\_\_ in groups \_\_\_\_\_ miss the phone ring \_\_\_\_\_ smoke alarm \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_\_\_ use oxygen? \_\_\_\_\_ Which ear do you use on the phone? \_\_\_\_\_\_\_\_\_

**General Health:**

How is your health currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any serious physical injury? \_\_\_\_\_ What \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When \_\_\_\_\_\_­­\_

***Please check all that apply:***

\_\_\_\_\_Bell’s Palsy \_\_\_\_\_Diabetes \_\_\_\_\_Dizziness \_\_\_\_\_Depression

\_\_\_\_\_High Blood Pressure \_\_\_\_\_Balance/Fall \_\_\_\_\_Meningitis \_\_\_\_\_Headaches

\_\_\_\_\_Parkinson’s \_\_\_\_\_Stroke/TIA \_\_\_\_\_ Memory issues \_\_\_\_\_Pace maker

\_\_\_\_\_Chemo treatment \_\_\_\_\_Chronic Kidney Disease

***Please list any medications or nutritional/herbal supplements you are taking:***

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Used for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Used for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Used for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Used for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any known allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional remarks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_