

PERSONAL HISTORY - ADULT

Full Name: _____

Date of Birth: _____

Reason for Today's Visit: _____

MEDICAL HISTORY

Medications: (including prescription, over-the-counter, herbal supplements).

Drug Name	Dosage	Frequency	Route

Have you had any of the following? Please check all that apply.

<input type="checkbox"/> Ear pain	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Ear popping
<input type="checkbox"/> Ear drainage	<input type="checkbox"/> Ear surgery	<input type="checkbox"/> Ear tubes
<input type="checkbox"/> Ear ringing	<input type="checkbox"/> Trauma (head/ear)	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Craniofacial Anomalies	<input type="checkbox"/> Dizziness or unsteadiness
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Alzheimer's or Dementia
<input type="checkbox"/> Autoimmune Disease (i.e., HIV, Lupus)	<input type="checkbox"/> Cancer	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Measles/Mumps		

List any operations with date of occurrence: _____

Other chronic illnesses: _____

Any drug or other allergies: _____

HEARING HEALTH HISTORY

Please check if you are experiencing: Hearing Difficulty Balance Problems Tinnitus

Do you hear people speaking but have difficulty clearly understanding what is being said? yes no

When did you first notice a hearing problem? _____ Was it gradual sudden fluctuating

What do you feel caused your hearing problem? _____

Have you seen a physician for your hearing problem? Yes No If yes, whom and when _____

Have you experienced any of the following:

Occasionally

Often

Always

Family/friends notice that you aren't hearing well?

Family/friends report that you have the TV volume too loud?

Do you ask people to repeat themselves?

Difficulty hearing on the telephone?

Difficulty hearing soft or distant voices?

Do any family members have a hearing problem? Yes

No

If yes, whom and what age was it identified? _____

Is hearing loss causing any issues at work? Yes

No

Please indicate all of the situations where you have been exposed to loud noises:

Work Home Hobbies Shooting guns Loud Music Other: _____

Did you wear hearing protection: Yes No

Please check any of the following situations where you notice hearing difficulty: Television Radio

Movies Place of Worship At a table with 4-6 people In noisy restaurants At a party

HEARING AID HISTORY

Have you ever worn a hearing aid(s)? Yes No If yes, which ear(s)? Right Left Both

What style are your hearing aid(s)? _____

When and where did you purchase the present hearing aid(s)? _____

Have the hearing aids been satisfactory or unsatisfactory, and why? _____

Please rate the following in order of importance to you (1 - Most Important, 3 - Least important)

	Ability to hear as well as I can
	Cosmetics - whether others can see them
	Price

Any other questions or comments? _____
