hearbright

Hearbright, an Audiology Corporation

Agility Hearing Care & Devices


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# MEDICAL HISTORY

| | | |
|---|---|---|
| **Last Name:** | **First Name:** | |
| **Date of Birth:** | **Age:** | **Current or Former Occupation:** |
| **Referred By: (Physician's Name)** | | |
| **Signature for release of medical information to above physician:** | | **Date:** |
| **If patient is a minor, print your name and relationship to patient:** | | |

**What is the reason for your hearing test today?**_____

**Please mark, circle, or briefly explain your main concern regarding your ears or hearing:**

| Yes/No | Description | Specify | When did symptom begin? | Comment |
|---|---|---|---|---|
| Yes/No | Gradual Hearing Loss? | (circle one or both)<br>Right Ear<br>Left Ear | | |
| Yes/No | Sensation of "Plugged Ear"? | (circle one or both)<br>Right Ear<br>Left Ear | | |
| Yes/No | Dizziness (Sensation of Spinning and Falling)? | Constant or Sometimes? | | |
| Yes/No | Feeling of Imbalance? | Constant or Sometimes? | | |
| Yes/No | Ear Pain? | (circle one or both)<br>Right Ear<br>Left Ear | | (circle one or both)<br>Constant<br>Sometimes |
| Yes/No | Ringing or Buzzing in Ear? | (circle one or both)<br>Right Ear<br>Left Ear | | (circle one or both)<br>Constant<br>Sometimes (more than 10 min duration) |
| Yes/No | History of Ear Infections? | (circle one or both)<br>Right Ear<br>Left Ear | | |
| Yes/No | Noise Exposure? | Firearms,<br>Firecrackers,<br>Machinery,<br>Trucks/Engines<br>Speakers | Are you still engaging in described activity? | |
| Yes/No | Family History of Hearing Loss or Ear Problems? | Hearing loss during later years in life<br>Ear Surgery<br>Deafness (circle one) | Mother<br>Father<br>Siblings<br>Other | |
| Yes/No | Ear Surgery | Right Ear or Left Ear? | When? | Type of Surgery |
| Yes/No | Head Trauma | | When? | |
| Yes/No | History of Hearing Aid Use? | (circle one or both)<br>Right Ear<br>Left Ear | When? | Describe: |
| Yes/No Refused | Current **medications**; | List: | | |