BAYSIDE AUDIOLOGY & HEARING AIDS

Audiologic and Medical History

Appointment Date: _____

Patient Name: _____ Date of Birth: _____Age:_____

Chief Complaint: Hearing Loss (Right Ear / Left Ear) Tinnitus/Ringing Dizziness

Difficulty Hearing (In Quiet / In Noise) Telephone

How long have you noticed this difficulty? _____ Date of Last Hearing Test: _____

Do you wear hearing aids? _____

Do you feel your hearing is changing? Yes / No (Gradual / Sudden)

Do you have any pain or drainage from your ears? Left Right Both No

Do you have any ringing/buzzing/humming/tinnitus in your ears? Left Right Both No

Do you have any difficulties with balance or Vertigo? Yes No Please describe: _____

Have you experienced extreme sensitivity to sound? Yes No Please describe: _____

Have you had any ear surgeries? Left Right No Date: _____

Have you had any recent colds? Yes No If so, when? _____

Do you have sinus/allergy/hay fever problems? Yes No Please explain: _____

Is there a family history of hearing loss? Yes No If yes, who? _____

Do you have any history of noise exposure? Yes No If yes, when and to what? _____

CURRENT MEDICATIONS:

Name of medication	Dosage	What is the medication taken for	Prescribing Physician

Do you have (currently or in the past) any of the following:

___Heart problems (cardiac)/ Pacemaker
___Diabetes / Hypoglycemia
___Vascular Problems
___Endocrine or Hormonal Problems
___Arthritis
___Head injuries
___Neurologic issues
___Kidney Disease
___Depression
___High Blood Pressure
___Stroke
___Blood Disorder
___Cancer
___Thyroid disorder
___HIV/Syphilis
___Meningitis

Have you used a tobacco product (cigarette/cigar/smokeless tobacco) one or more times in the past 24 months? Yes/ No
-If yes, how often have you used a tobacco product in the past 24 months? _____