Hearing Health Assessment

Patient Name _____ Date _____

General History

When was your last hearing exam? _____ By whom? _____

What were the recommendations? _____

How long ago did you notice a decline in your hearing?

Within past 90 days? 1-3 years 4-6 years 7-10 years 10+ years

Has anyone in your family suffered hearing loss? YES NO If yes, whom? _____

Do you have a history of:

Earaches `	YES	NO	Dizziness	YES	NO
Allergies to plastic	YES	NO	Head Injury	YES	NO
Drainage	YES	NO	Noise Exposure	YES	NO
Ringing in ears	YES	NO	PE Tube(s)	YES	NO
Pain/Discomfort in ears	YES	NO	Cerumen (wax) buildup	YES	NO

Medical History

Diabetes	YES	NO	Radiation therapy to local area	YES	NO
Regular MRIs?	YES	NO	Chemotherapy within 6 months	YES	NO
TMJ	YES	NO	Autoimmune Disease	YES	NO
Cancer	YES	NO	Stroke/vascular incident	YES	NO
Coronary Heart Disease	YES	NO	High Blood Pressure	YES	NO
Multiple Sclerosis	YES	NO	Family history of hearing loss	YES	NO

Use of Tobacco product (cigarette, cigar, smokeless tobacco etc.) one or more times in past 24 months

YES NO

If yes, how often have you used a tobacco product in the past 24 months?_____

If yes, what type of products have you used?_____

Allergies to any medications: _____

Current medications including prescription medication, OTC, herbals, vitamin/mineral/dietary nutritional supplements) including dose and frequency

_____

_____

_____

Have you ever had ear surgery? YES NO If Yes, which ear? LEFT RIGHT

Type_____

Please list other medical conditions: _____

_____

_____