A ADVANCED
AUDIOLOGY INSTITUTE

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Patient Name _____ Age ____ date ___/___/____
First MI Last MM DD YY

GENERAL HISTORY

Is this your first hearing exam? ◯ YES ◯ NO
If not, when was your last exam? _____ By Whom: _____
What were the recommendations? _____

How long ago did you notice a decline in your hearing?
◯ RECENTLY ◯ 1-3 YEARS ◯ 4-6 YEARS ◯ 7-10 YEARS ◯ MORE THAN 10 YEARS

Have you ever used hearing instruments or assistive listening devices? ◯ YES ◯ NO
In which ear is your hearing poorest? ◯ RIGHT ◯ LEFT ◯ SAME
Which ear do you use on the telephone? ◯ RIGHT ◯ LEFT ◯ EITHER

	YES	NO
Do you experience frequent dizziness or unsteadiness?	◯	◯
Are you experiencing any drainage from the ear(s)?	◯	◯
Are you experiencing any ear pain?	◯	◯
Do you have a family history of hearing loss?	◯	◯
Do you have a feeling of fullness in your ears?	◯	◯
Do you have a history of ear infections?	◯	◯
Do you have a history of ear-wax build-up?	◯	◯
Have you had an excessive exposure to noise?	◯	◯
Do you have a history of military service?	◯	◯
Do you have a history of firearm use?	◯	◯
Do you have sinus or allergy problems?	◯	◯
Are you experiencing Tinnitus (ringing in the ears)?	◯	◯

MEDICAL HISTORY

Reason for today's appointment _____
Allergies to any food, medications, plastics, etc.? _____
Current medications: _____

Have you ever had ear surgery? ◯ YES ◯ NO
Type of surgery _____
Please list all major surgeries _____
Please list any serious illnesses _____

ARE YOU DIABETIC? ◯ YES ◯ NO