Patient History

Name: _____ Date: _____

Do you feel you have hearing loss? YES NO

If yes, how long have you been experiencing hearing difficulties? _____

If yes, do you feel that your hearing sensitivity is getting worse? _____

Have you ever worn hearing aids? YES NO

Do you experience ringing or buzzing in your ears? YES NO

Do you experience dizziness or balance problems? YES NO

Do you experience pain/discomfort in your ears? YES NO

Have you ever had ear surgery? YES NO

Is there a history of hearing loss in your family? YES NO

Do you have a history of noise exposure? YES NO

Do you smoke or use tobacco? YES NO

Primary Reason for Today's Visit:

Other Relevant Health Information:

Medications:

Name	Purpose	Length Taken