



Insurance Questions?
Call our Insurance Specialist
544-6210

Adult Hearing Health History

Legal Name: _____ Date of Birth: _____

Gender: _____ Name you go by (if different than legal name): _____

Primary Care Physician: _____ Current/Former Occupation: _____

What is the reason for your visit (primary concern)? _____

How did you hear about us: Television Radio Phone Book Internet Mailer Family/Friend
 Physician Other: _____

Hearing History: If you answer YES to any questions, please explain further.

Yes No Do you feel you have a hearing loss? Is one ear worse? Right Left No Difference
Has your hearing loss occurred gradually or very suddenly? Gradual Sudden
Approximately when did you first notice your hearing loss? _____

Yes No Have you ever had your hearing tested? When, where, & results: _____

Yes No Have you ever worked in a loud place or participated in loud activities? Explain: _____

Yes No Do/did you consistently use hearing protection at work or during these loud activities?

Yes No Do you hear ringing or buzzing in your ears (tinnitus)? If yes, when did it start? _____
Which ear(s): Right Left Both Does it bother you? Yes No
Is the tinnitus constant or occasional? Constant Occasional

Yes No Does anyone else in your family have difficulty hearing? Who? _____

Medical History: If you answer YES to any questions, please explain further.

Yes No Do you have a history of ear infections or ear surgery?
Explain: _____

Yes No Have you ever seen a doctor for an ear-related issue?
Name of doctor, date and reason for visit: _____

Yes No Pain in your ears? Which ear(s): Right Left Both

Yes No Drainage from your ears (that is not wax)? Which ear(s): Right Left Both

Yes No Dizziness? Is it: Constant Occasional

Yes No Imbalance? Is it: Constant Occasional

Yes No Do you have any allergies (ex. Latex, Acrylic, dyes)? _____

Yes No Have you ever had chemotherapy or radiation? _____

Yes No Have you ever had IV antibiotics? _____

Yes No Do you currently reside with someone? Who? _____

Yes No Have you used a tobacco product (cigarette, cigar, smokeless tobacco) at all in the past 24 months? What type(s) of products and how often? _____

Revised 11/11/24

