AMERICAN EAR
HEARING & AUDIOLOGY INC.

PATIENT HISTORY

Name _____ Date of Birth _____ Today's Date _____

How did you hear about us? _____

Why have you decided to have your hearing tested at this time?

_____

Do you wear any type of ear protection?	❑ Yes	❑No		
Have you been examined by a doctor in the past 6 months?	❑ Yes	❑No		
Have you had your hearing tested? When? _____	❑ Yes	❑No		
Do you have any associated Vertigo / Dizziness?	❑ Yes	❑No		
In which ear is your hearing worse?			R_____	L_____
Do you wear hearing aids?	❑ Yes	❑No	R_____	L_____
Have you had any ear surgeries?	❑ Yes	❑No	R_____	L_____
List any ear surgeries and date _____				
Do you have any history of noise exposure?	❑ Yes	❑No	R_____	L_____
If so, what type of noise were you exposed to and how long? _____				
Any pain or discomfort in the ear(s)?	❑ Yes	❑No	R_____	L_____
Do you have any ringing or noises (Tinnitus) in either ear?	❑ Yes	❑No	R_____	L_____
Has a doctor ever removed wax from your ears?	❑ Yes	❑No	R_____	L_____
Do you know the cause of your hearing loss?	❑ Yes	❑No		

COMMUNICATION ASSESSMENT:

(If you wear hearing aids, answer how you hear with them)

How did your hearing loss develop?	❑ Suddenly		❑Gradually
Has a spouse or friend told you that you don't hear well?	❑ Yes	❑No	
Do you hear people speaking but have difficulty understanding the words?	❑ Yes	❑No	
Do you find yourself asking people to repeat what they have said?	❑ Yes	❑No	
Do you find it difficult to hear in noisy places?	❑ Yes	❑No	
Have you been told that you speak loudly?	❑ Yes	❑No	
Do you find it difficult to understand speech when your back is to the speaker?	❑ Yes	❑No	
Do you have difficulty understanding on the phone?	❑ Yes	❑No	
Do you find yourself asking others to come closer or speak louder so you can hear them?	❑ Yes	❑No	
Have you ever avoided social situations because it is difficult to hear and participate in the conversations?	❑ Yes	❑No	
Do you have to concentrate so intently on hearing what people are saying that you sometimes get tired or frustrated?	❑ Yes	❑No	
Do you have difficulty knowing from which direction sounds are coming?	❑ Yes	❑No	

Hearing Aid User:

My hearing aid(s) don't make the sounds loud enough.	❑ Yes	❑No
My hearing aid(s) make sounds tinny.	❑ Yes	❑No
My hearing aid(s) whistles.	❑ Yes	❑No
My hearing aid(s) makes my ear sore.	❑ Yes	❑No