HEARING HEALTH REPORT

CLIENT HISTORY

PLEASE PRINT

Today's Date _____ - _____ - _____

Last Name _____ First Name _____ MI _____

Address _____ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Widow(er)

City _____ State _____ Zip _____ County _____

Phone ( ) _____ - _____ E-mail Address _____

Date of Birth _____ - _____ - _____ Past/Present Occupation _____

Accompanying Party or Companion _____ Relationship _____

Family Physician Name _____ City _____ Phone _____

Insurance Carrier _____ I.D. No./Policy No. _____

Permission to release a copy of test information to physician? ❑ Yes ❑ No Patient's Signature _____

MEDICAL AND HEARING HEALTH HISTORY

Do you have any allergies? ❑ Yes ❑ No If yes, please list _____

Are you a diabetic? ❑ Yes ❑ No If yes, are you insulin-dependent? _____

Do you have arthritis/rheumatoid arthritis? ❑ Yes ❑ No

Are you currently taking any medications? ❑ Yes ❑ No If yes, please list _____

Are you taking any blood thinners? ❑ Yes ❑ No If yes, please list _____

Do you have ringing or other noises in your ears? ❑ Yes ❑ No If yes, which ear? _____

Have you previously had a hearing test? ❑ Yes ❑ No If yes, by whom and when? _____

Have you received any medical or surgical treatment for your hearing loss? ❑ Yes ❑ No

If yes, when? _____ Explain _____

Physician/ENT _____ City _____ Phone _____

AMPLIFICATION HISTORY

Are you a current hearing aid wearer? ❑ Yes ❑ No Type _____ Ear fitted: ❑ Both ❑ Left ❑ Right

If yes, and you could improve something about your current hearing aids, what would that be? _____

_____

Do you know anyone who wears hearing aids? ❑ Yes ❑ No If yes, who? _____

OTOSCOPIC EXAM AND FDA QUESTIONS

Otoscopic Exam: Right Ear _____ Left Ear _____

- Visible congenital or traumatic deformity of the ear? ❑ Yes ❑ No
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? ❑ Yes ❑ No
- Any history of, or active drainage from, the ear within the previous 90 days? ❑ Yes ❑ No
- Any history of sudden or rapidly progressive hearing loss within the previous 90 days? ❑ Yes ❑ No
- Have you experienced any acute or chronic dizziness? ❑ Yes ❑ No
- Is there a unilateral hearing loss of sudden or recent onset within the previous 90 days? ❑ Yes ❑ No
- Have you experienced any pain or discomfort? ❑ Yes ❑ No
- Audiometric air-bone gap equal to, or greater than 15dB at 500 Hz, 1000 Hz and 2000 Hz? ❑ Yes ❑ No

Hearing Care Professional _____ License # _____