HarmonyHearing & Audiology

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ADULT PATIENT HISTORY

Name_____ Date _____

Are you currently experiencing **hearing difficulties**? ☐ Yes ☐ No If so, how long? _____

Has your **hearing changed** over time? ☐ Declined ☐ Improved ☐ Fluctuated ☐ Remained Stable

On a scale from 1 to 10, 1 being the worst and 10 being the best, how would you rate **your overall hearing ability**?

(please circle one) 1 2 3 4 5 6 7 8 9 10

Do you feel like one ear is significantly **worse** than the other? ☐ Right Ear ☐ Left ear ☐ No Significant Difference

Have you ever worn **hearing aids**? ☐ Yes ☐ No If so, how long? _____

Have you recently experienced any of the following?

☐ Sudden Change in Hearing ☐ Ear Pain ☐ Ear Pressure/Fullness ☐ Ear Drainage ☐ Other _____

Have you experienced **dizziness or vertigo** during the past 90 days? ☐ Yes ☐ No

Have you been exposed to **loud noises** in the past (more so than average)? ☐ Yes ☐ No If so, what type?

☐ Occupational/Work ☐ Military ☐ Loud Music ☐ Gunfire ☐ Power Equip. ☐ Other _____

Do you hear noises, ringing, or **sounds in your ears** lasting longer than 2 minutes at a time? ☐ Yes ☐ No

Has anyone in your **family** experienced hearing loss? ☐ Yes ☐ No If so, who? _____

Have you ever experienced any of the following?

☐ Allergies	☐ Head Injury	☐ Neurological Problems	☐ Surgery of the head or ears
☐ Cancer	☐ Heart Problems	☐ Sinus Problems	☐ High Cholesterol
☐ Diabetes	☐ High Blood Pressure	☐ Stroke/TIA	☐ Endocrine Problems

Are you currently taking any **prescription medications**? ☐ Yes ☐ No

Do you utilize **tobacco products**? ☐ Yes ☐ No

Additional Comments _____

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