Harmony Hearing & Audiology
5 Bel Air South Pkwy., Ste 1411
Bel Air, Maryland 21015
Phone: (410) 569-5999 Fax: (443) 320-9468

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 _____