Audiology Concepts, LLC

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Patient Name ______________________________________ Appointment Date:

1. Chief complaint: ❐Hearing Loss (❐ Right ear/ ❐Left ear/ ❐Both) ❐Tinnitus/Ringing

2. How long have you noticed this difficulty? ____

3. Have you ever been exposed to loud noise, either recently or in the past? r Yes r No
   If so, please mark all that apply:
   ❐Farm Machinery ❐Music ❐Hunting/Shooting ❐Factory Noise
   ❐Power Tools ❐Military ❐Jet Engines ❐Other:

4. Do you have any of the following symptoms? ❐Deformity of the ear ❐ Drainage of the ear
   ❐Sudden or rapid loss within the past 90 days ❐Tinnitus(ringing) ❐Ear pain

5. Have you ever had your hearing tested? ❐Yes ❐No If so, when was your last test? __________________

6. Have you seen an Ear, Nose and Throat Physician? ❐Yes ❐No
   If so, who did you see? _________________________________When? _______________________

7. Is there a history of hearing loss in your family? ❐Yes ❐No If so, who? ____________________________

8. Have you ever had an ear infection? ❐Yes ❐No (If yes, ❐as a child ❐as an adult)

9. Please check any of the following that you currently have or have had in the past:
   ❐Arthritis ❐Heart Trouble ❐Measles ❐ Parkinson's
   ❐Asthma ❐Hepatitis ❐Meningitis ❐Scarlet Fever
   ❐Bell's Palsy ❐High Blood Pressure ❐Mumps ❐Sinusitis
   ❐Diabetes ❐HIV ❐Neurological ❐Stroke/TIA
   ❐Head Injury ❐Malaria ❐Symptoms ❐Visual Trouble-Loss/Sight

10. If you are currently using a hearing aid, or have in the past, please answer the following:
    Which ear is/was aided? ❐Right ❐Left ❐Both
    How long have you used a hearing aid? ____

    When were your hearing aids purchased? ____

11. Please rank the following in order of importance (1 to 4 - 1 being most important and 4 least important) if a hearing aid is recommended for you:
    ____ Improved hearing in quiet ____ Improved hearing in noise
    ____ Cosmetic appearance ____ Expense

12. List 3 situations where you would like to hear better.

    ____

    ____

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Have you ever experienced dizziness, unsteadiness, imbalance or vertigo. ❐Yes ❐No

If yes, are you feeling dizzy today? ❐Yes ❐No

If yes, please describe: ______________________________

Frequency of occurrence: ______________________________

If yes, is it accompanied by:

❐nausea ❐ringing or noises in your ear ❐hearing loss ❐visual disturbances

Have you fallen within the past 12 months? ❐Yes ❐No

If yes, how many falls have you experienced in the last 12 months: ________

If you have fallen, have you been injured: ❐Yes ❐No

Please describe your injury: ______________________________

Do you experience visual difficulties or disturbances? ❐Yes ❐No

____

Do you currently take a Vitamin D supplement? ❐Yes ❐No

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months. ❐Yes ❐No

If yes, how often have you used a tobacco product in the past 24 months? ________

If yes, what type(s) of products have you used: ______________________________

Current Medications List -Please Print Clearly

Drugs	Dosage	Frequency	Route
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

Over the Counter Drugs	Dosage	Frequency	Route
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

Herbals/Vitamin/Dietary Supplements	Dosage	Frequency	Route
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

Audiologist Name: ______________________________ Initials______ Date:______________