**Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of completion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_Primary language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Medications:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Drug Name** | **Dosage (mg)** | **Frequency (how often)** | **Route (how do you take it)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Allergies (food, medications, plastics, etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other illnesses, surgeries, injuries, hospitalizations since birth and their approximate date of occurrence(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you experienced any of the following major medical conditions (please check all that apply)

* AIDS/HIV
* Anxiety
* Arthritis
* Blood disorders
* Cancer
* Chicken Pox
* Depression
* Diabetes
* Diphtheria
* Encephalitis
* Fatigue
* Genetic Disorder
* Headaches
* Head Injury
* Heart Problems
* High Blood Pressure
* High Fevers
* Influenza
* Malaise
* Malaria
* Measles
* Meningitis
* Mumps
* Scarlet Fever
* Stroke
* TMJ
* Typhoid
* Vascular Problems
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle all medical symptoms or conditions that apply:

* Eye problems (blurred or double vision, pain): YES/NO
* Nose, throat or mouth problems (trouble swallowing, nose bleeds, dental issues): YES/NO
* Cardiovascular issues (hypertension, chest pain, swelling, palpitations): YES/NO
* Respiratory issues (such as shortness of breath, cough. wheezing): YES/NO
* Renal issues (such as kidney issues, dialysis): YES/NO
* Gastrointestinal issues (nausea, vomiting, weight changes, diarrhea, pain): YES/NO
* Musculoskeletal issues (joint pain, swelling, recent trauma): YES/NO
* Neurological symptoms (numbness, headaches, tingling, seizures, weakness): YES/NO
* Psychiatric issues (depression, anxiety, compulsions): YES/NO
* Endocrine symptoms (frequent urination, hot flashes): YES/NO
* Hematologic/lymphatic symptoms (bleeding gums, bruising, swollen glands): YES/NO
* Allergic/immunologic symptoms (hives, asthma, itching, immune deficiency): YES/NO

Comments related to Review of Symptoms above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use recreational drugs? YES/NO

If yes, what drugs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use any tobacco products: YES/NO

Do you currently drink alcoholic beverages: YES/NO

If yes, how often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all conditions that apply:

* Dizziness or Unsteadiness If checked, is it accompanied by: vomiting, nausea, ear noises
* Ear deformity Right ear Left ear Both ears
* Ear drainage Right ear Left ear Both ears
* Ear pain Right ear Left ear Both ears
* Family history of hearing loss Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* History of ear infections Right ear Left ear Both ears When?\_\_\_\_\_\_\_\_\_\_\_
* History of noise exposure Please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Previous ear surgery Right ear Left ear Both ears When?\_\_\_\_\_\_\_\_\_\_\_
* Tinnitus Ringing/Noise in ear Right ear Left ear Both ears How often?\_\_\_\_\_\_\_
* History of wax buildup Right ear Left ear Both ears How often?\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you experience hearing loss? Right ear Left ear Both ears

When did you first notice your hearing loss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you think caused your hearing loss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a hearing test? Yes/No If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you experience hearing loss, which best describes it? Gradual Fluctuating Sudden

Have you worn or tried a hearing aid? Right ear Left ear Both ears

Please describe your hearing aid experience:

I have a hearing aid, but I don’t use it, or only use it occasionally.

I have tried a hearing aid but returned it.

I have inquired about a device from another office but did not purchase.

What motivated you to come in today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10, where do you feel you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? Please circle one

Not motivated 1 2 3 4 5 6 7 8 9 10 Very motivated