Case History

Patient Name: ____ DOB: _________________ Date: __________________

Reason for Visit: ____

Please check conditions that apply:

___ **Previous Hearing Test?**	RESULTS: ____					
___ **Family History of Hearing Loss**						
___ **History of Noise Exposure**						
___ **Difficulty Hearing**	RIGHT	LEFT	BOTH EARS	GRADUAL	FLUCTUATING	SUDDEN
___ **Pressure in the Ears**	RIGHT	LEFT	BOTH EARS			
___ **Earwax Buildup**	RIGHT	LEFT	BOTH EARS			
___ **Previous Ear Surgery**	RIGHT	LEFT	BOTH EARS	_________________________________		
___ **Ear Pain**	RIGHT	LEFT	BOTH EARS			
___ **Ear Drainage**	RIGHT	LEFT	BOTH EARS			
___**Tinnitus(ringing/roaring/buzzing)**	RIGHT	LEFT	BOTH EARS	FREQUENCY: ________________		
___ **Use of a Hearing Aid**	RIGHT	LEFT	BOTH EARS	HOW LONG: ________________		

Do you have trouble hearing in any of the following situations? (Check all that apply)

___**TV**	___**Family Members**	___ **Work**	___ **Worship**
___**Phone**	___ **Social Gatherings**	___ **Restaurants**	___**Meetings**

___ **Other:** ____

Have you experienced any of the following major medical conditions? (Check all that apply)

___**Autoimmune Disorder**	___ **Requirement of Blood Thinner**	___**Chemotherapy**	___**Diabetes**
___**History of Ear Infections**	___**Implantable devices**	___**Meningitis**	___ **Dizziness**
___ **Radiation (Head/Neck)**	___**Stroke or Head Injury**	___ **Dementia**	___**Arthritis**

___ **Other:** ____

How did you find out about our clinic? ____

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