Audiology HEARS

Health History

Patient Name _____ Date _____

Date of Birth _____

Medical

Do you have a history of any of the following (circle all that apply):

High Blood Pressure	Meningitis	Vision loss	Diabetes	Smoking
TMJ	Heart Problems	Head injury	Sinusitis	Bell's Palsy
Measles	Parkinson's	Stroke/ TIA	Shingles	HIV/AIDS
Neurological problems	Dementia	Pacemaker	Thyroid problems	

Cancer --- If yes, what type of cancer? _____

Did you receive radiation? ◯ Yes ◯ No Did you receive chemotherapy? ◯ Yes ◯ No

Please list the medications you take: _____

_____

Ear/ Hearing

Do you have a history of any of the following:

Ear Surgery	◯ *Yes* ◯ *No*	*Please describe:*_____
Loud noise exposure	◯ *Yes* ◯ *No*	*Please describe:*_____
Ear infections	◯ *Yes* ◯ *No*	
Fluid draining from your ears	◯ *Yes* ◯ *No*	
Sudden hearing loss	◯ *Yes* ◯ *No*	**If so, when:**_____ **Which Ear?** ◯ **Right** ◯ **Left**
Gradual hearing loss	◯ **Yes** ◯ **No**	**Which Ear:** ◯ **Right** ◯ **Left**
Born with hearing loss	◯ **Yes** ◯ **No**	**Which Ear:** ◯ **Right** ◯ **Left**
Excessive ear wax buildup	◯ **Yes** ◯ **No**	
Dizziness or vertigo	◯ **Yes** ◯ **No**	
Family member with hearing loss	◯ **Yes** ◯ **No**	**If so, who?** _____
Ringing in the ear	◯ **Yes** ◯ **No**	**If so, which ear?** ◯ **Right** ◯ **Left**
		If so, is the ringing constant? _____

Communication Concerns

Please answer the following questions:

Do you have difficulty hearing when someone is soft spoken or speaks at a distance? ◯ **Yes** ◯ **No**

Do you have difficulty communicating when you are at social events (i.e. restaurants or large groups)? ◯ **Yes** ◯ **No**

Do you have difficulty understanding the television or radio? ◯ **Yes** ◯ **No**

Do you have difficulty communicating with your family and friends? ◯ **Yes** ◯ **No**

Do your communication concerns cause you to have arguments with family members? ◯ **Yes** ◯ **No**

HEARING AID HISTORY

Do you currently wear hearing aids? ◯ **Yes** ◯ **No**

If so, how long have you worn hearing aids? _____

Are you pleased with the performance of your hearing aids? ◯ **Yes** ◯ **No**

If not, explain any concerns you have with your hearing aids: _____

Motivation Scale

On a scale of 1-10, where do you feel that you are regarding doing something about your hearing loss?

(Please circle one):

1	2	3	4	5	6	7	8	9	10
Not Motivated				**Somewhat Motivated**				**Very Motivated**	

Please read and sign below.

- I give permission to this practice to release information, verbal and written (contained in my medical record and other related information), to my insurance company, case manager, attorney, related health care providers, and all other related persons.
- I authorize this practice to use and release my contact information for marketing related to hearing care products and services.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPPA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet and certify that this information is true and accurate to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.

I have read and understand all the above information.

_____

Patient (or Guardian) Signature **Date**