



# Hearing Health Assessment

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## General History

When was your last hearing exam? \_\_\_\_\_ By whom? \_\_\_\_\_

What were the recommendations? \_\_\_\_\_

How long ago did you notice a decline in your hearing?

- Within past 90 days     1-3 years     4-6 years     7-10 years     10+ years

Have you ever used assistive listening devices?     Yes     No

Do you suffer from acute or chronic dizziness?     Yes     No

Has anyone in your family suffered hearing loss?     Yes     No

If yes, who? \_\_\_\_\_

## Medical History

Please indicate which of the following diseases/injuries/problems you have had:

- |                                |                            |                                   |
|--------------------------------|----------------------------|-----------------------------------|
| Measles _____                  | Mumps _____                | Polio _____                       |
| Malaria _____                  | Diabetes _____             | Stroke/Aneurysm _____             |
| Arthritis/Rheumatoid _____     | Rheumatic fever _____      | Chicken pox _____                 |
| Severe Burns _____             | Hepatitis _____            | Seizure disorder _____            |
| Kidney disease _____           | Allergies/Sinus _____      | High/Low blood pressure _____     |
| Scarlet fever _____            | Meningitis _____           | Pneumonia _____                   |
| Tuberculosis _____             | Cancer _____               | Heart disease _____               |
| Head Trauma _____              | Headaches _____            | Ear infections _____              |
| Ear pain _____                 | PE tubes _____             | Cerumen (wax) build up _____      |
| _____                          |                            |                                   |
| TMJ _____                      | Alzheimer's/Dementia _____ | Ear drainage (past 90 days) _____ |
| _____                          |                            |                                   |
| Tinnitus (noise in ears) _____ | Chemotherapy _____         |                                   |

Have you ever been exposed to loud noises?    Yes    No

Please indicate the noises that you have been exposed to:

- |                   |                        |                       |
|-------------------|------------------------|-----------------------|
| Gunfire _____     | Explosions _____       | Factory noise _____   |
| Power Tools _____ | Motorcycle _____       | Power mower _____     |
| Loud music _____  | Military Service _____ | Heavy Equipment _____ |

Please list any other concerns you may have that have not been addressed: \_\_\_\_\_

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