



Hearing Health Assessment - New Patients

Arizona Hearing
—SPECIALISTS—

Patient Name _____ Date _____

Medical History

Reason for today's appointment _____

Allergies to any medication, plastics etc.? _____

Current Medications *(Please Complete the attached Prescription Medication List)*

Have you ever had ear surgery? Yes No If Yes, which ear? Right Left

Type _____

Please list all major surgeries *(past 10 years)* _____

Please list any serious illnesses *(past 10 years)* _____

Are you diabetic? Yes No

Are you a smoker? Yes No Exposed to secondhand smoke? Yes No

History of cardiovascular disease? Yes No

Hearing History

When was your last hearing exam? _____ By whom? _____

What were the recommendations? _____

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

Recently 1-3 years 4-6 years 7-10 years More than 10 years

Have you ever used assistive listening devices? Yes No

In which ear is your hearing the poorest? Right Left Same

Which ear do you use on the telephone? Right Left Either

Have you experienced a sudden or progressive hearing loss within the last 90 days? Right Left Both Neither

Have you experienced any drainage from your ear(s) within the last 90 days? Right Left Both Neither

Do you suffer from pain or discomfort in your ear(s)? Right Left Both Neither

Do you suffer from acute or chronic dizziness? Yes No

Is there visible congenital or traumatic deformity of the ear? Yes No

Do you experience tinnitus (ringing in the ears)? Yes No

Describe _____

Any history of ear infections? Yes No

Are there any other members of your family who have a hearing problem? Yes No

Are you now or have you ever worked in a noisy place? Yes No

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