



East Valley Hearing Center

"Professional Service with a Caring Touch"

a member of AUDIGY GROUPSM

6262 E. Broadway Rd., Ste. 103
Mesa, Arizona 85206
(480) 830-0994

Hearing Health History

GENERAL HISTORY

Name: _____ Date: _____

Reason for today's appointment: _____

Is this your first hearing exam? Yes No If not, when was your last exam? _____

Have you seen a physician for your hearing loss? _____ If yes, whom did you see? _____

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

Who first noticed your hearing problem? _____

Was the onset gradual or sudden? _____

What do you feel caused the hearing problem? _____

Have you ever been exposed to loud noises at work or in your hobbies? (i.e. guns, power tools, tractors, loud music) _____

Have you ever used hearing instruments or assistive listening devices? Yes No

In which ear is your hearing poorest? Right Left Same

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

FAMILY HISTORY

Does anyone in your family have a hearing loss? _____

Who and at what age was it identified? _____

MEDICAL HISTORY

General current medical condition: Poor Fair Good Excellent

Are you allergic to any food, medications, plastics, etc? _____

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

List any operations (past 10 years): _____

List serious illnesses (past 10 years): _____

List all current medications: _____

Are you diabetic? Yes No

Please continue on the next page.

HEARING HISTORY

- Do you experience frequent dizziness or unsteadiness? Yes No **When?** _____
- Do you have any ear deformities? Yes No **When?** _____
- Are you experiencing any drainage from the ear(s)? Yes No **When?** _____
- Are you experiencing any ear pain? Yes No **When?** _____
- Do you have a feeling of fullness in your ears? Yes No **When?** _____
- Do you have a history of ear infections? Yes No **When?** _____
- Do you have a history of ear wax build-up? Yes No **When?** _____
- Do you have a history of military service? Yes No **When?** _____
- Do you have a history of firearm use? Yes No **When?** _____
- Do you have sinus or allergy problems? Yes No **When?** _____
- Are you experiencing tinnitus (ringing in the ears)? Yes No **When?** _____
- Do you experience nausea? Yes No **When?** _____
- Have you had a head trauma? Yes No **When?** _____