Name_____ Birth Date_____/_____/_____
First Middle Last

Preferred Name_____ Appointment Date _____/_____/20_____

Accompanied by: _____
(Names and Relationships)

Brothers and Sisters Names and Ages: _____
_____

Your Face to Face Communication			
Spoken English	Sign Language		
Bilingual	Other Languages (List)		
ASL	Other (List)		
Name of School:		Grade:	
How did your find out about us?			
Advertisement	School	Friends	Insurance
Internet	Physician	Relatives	Other
Names of Referral:			

Primary reason for today's visit_____
_____

CURRENT HEARING

Please think about the following situations in the past 30 days. (If your hearing fluctuated, use your best estimate of today's hearing.)	**Always Problem**	**Generally**	**About Half**	**Sometimes**	**No Problem**
Confusing similar sounding words					
Difficulty with rapid (fast) speech					
Problems following directions					
Spelling, Reading, or Writing problem					
Distracted by background noise					
Like TV louder than normal					
Understanding a speaker from a distance					
How often others say that you don't hear					
You feel your hearing worries or annoys you					

Please read each question and ***Circle***, ***Fill***, or ***Underline*** your answer.

Normally which is your Better Ear?	Left Ear	Right Ear	Similar		
Except for ear infections, was your better ear different in the past?	No	Yes			
Assistive Listening Device Used:	Alerting	Audio Loop	Captioned TV	Remote Mic	Wearable Amplifier
List any hearing aids worn with dates and which ear _____					
Phone Use (Select all that Apply)	Left Ear	Right Ear	Either	Amplified	Captioned	Speaker Mode
Are you	Left Handed	Right Handed	Mixed Handed		

Factors Contributing

In the last 90 days have you had any of the following?				No	
Sudden or Rapid Loss of Hearing	LE	RE	Both		
Ear Pain or Discomfort	LE	RE	Both		
Ear Drainage, Bleeding, Open Sores	LE	RE	Both		
Fullness, Pressure in Ear	LE	RE	Both		
Hearing better some days than others	LE	RE	Both		
Do you have any tinnitus? (Noises in your Ears or Somewhere in Head)				No	Yes
If "Yes" where did it start?	LE	RE	Both	Head	
Is the pitch:	**High** (bird chirp, insects)	**Low** (deep like a fog horn)	**Other** _____		
The Noise Occurs:	Occasional	Often	Constant		
Do you hear it now?				No	Yes
How often can you ignore it?	Never	Rarely	Usually	Almost Always	
Any sensitivity to certain sounds or loud sounds (vacuum cleaner)?				No	Yes
List any Balance, Coordination, or Dizziness issues _____					
_____					
Is there a family history of hearing loss before 30 years of age?				No	Yes
If "Yes," Who? _____					
If know, Why? _____					

History of Loud Noise Exposure

Concert	Gunfire	Jet Ski	Lawn/Tool
Motorcycle	Played in Band	Stereo Headphones	Other_____
Noise Incidents:_____			

Have you been exposed to Stereo Headphones within the last 14 hours?	No	Yes
Have you been exposed to loud noise within the last 14 hours?	No	Yes
If "Yes" did you wear Ear Protection?	No	Yes

Type of Ear Protection:	Foam Earplugs	Wax Balls	Earmuffs	Silicon Plugs	Universal Earplugs	Custom	Other

MEDICAL

Primary Physician: _____ Location: _____
(Full Name)

Do you have Allergies of any kind? (Seasonal or Constant, Skin Contact, Medication) No Yes

Please list all Allergies:_____

Have you sustained a Head injury? (Car Accident, Concussion, Fall, Other) No Yes

If "Yes" When and What happened? _____

Last Vision Examination date and results _____

Ear Wax Management: None; Ears Self-Clean Method at Home Others have Removed

If "Others" have removed wax, approximate number of times. _____

Fungal Ear Infection? No Yes

Hole in Eardrum? (Currently) in LE RE (Previously) in LE RE

Please list any ENT, Otologist consult/surgery _____

Do you have any of the following: (Select all that apply)

Infection at birth or in utero (e.g. CMV, herpes, rubella, syphilis, toxoplasmosis) _____

Postnatal infection associated with hearing loss (e.g. herpes, meningitis) _____

Syndromes associated with hearing loss (e.g. neurofibromatosis, Usher syndrome, Waardenburg syndrome, CHARGE, Down syndrome)_____

Neonatal intensive care for more than 5 days _____

Serious illness or medical problems (e.g. fever over 104°F, measles, Diabetes, etc.) _____

Ototoxic medications (e.g. gentamycin, aminoglycoside, loop diuretics) _____

Are you under the care of a Medical or Educational Specialist? No Yes

If "Yes" First and Last Name and Specialty _____

_____

Do you take any Medication or Supplements on a regular basis? No Yes

Please List Medication (Or provide a separate list to us)

Medication	Dosage (Strength)	Frequency	Form (Pill, Injection, Patch)	Reason for Medication

_____ _____
(Signature of Person Completing Form) (Date)