

Case History

Name: _____ Date: _____
Last First Middle initial

Companion name: _____

1. Who encouraged you to visit our clinic today? _____

2. Chief complaint: _____

3. Previous hearing test: Yes _____ No _____

4. What have you noticed about your hearing / communication ability?

5. How long have you noticed difficulties? _____

6. Hearing loss: Both _____ Right _____ Left _____ Comments _____

7. Family history: _____

8. Sudden hearing loss in the past 90 days? _____

9. Ear surgeries or medical problems with ears (drainage): Yes ___ No ___
Comments _____

10. Noises in your ears (Tinnitus): Yes ___ No ___ Comments _____

11. Dizziness (Vertigo): Yes ___ No ___ Comments _____

12. Head injuries: Yes ___ No ___ Comments _____

13. Systemic disorders: Mumps _____ Measles _____ Renal Problems _____
Diabetes _____ Infections _____ Other _____

14. Medications: _____

15. Excessive noise exposure: Occupational _____ Recreational _____

16. Hearing Aid: Yes _____ No _____
Type: Body _____ BTE _____ ITE _____ Canal _____ CIC _____
Ear: Right _____ Left _____ Both _____
Make: _____ Model: _____
Date Purchased: _____ Where Purchased: _____
Comments: _____

17. How did you hear about Hearing Solutions?

Advertisement Doctor Referral Internet

Friend / Family Other _____