Horan & Fevold Hearing Clinic, PLLC

PATIENT HISTORY

Name:_____ **DOB:**_____ **Today's Date:**_____

	YES	NO
▪ Have you seen a doctor in the past 6 months? [Dr. _____]	❒	❒
▪ Have you seen a doctor specializing in diseases of the ear?	❒	❒
▪ Have you ever had your hearing tested?	❒	❒
❒ If yes, when and where? _____		
▪ Do you have noises or ringing in your ears (tinnitus)?	❒	❒
▪ Do you have a family history of hearing loss?	❒	❒
▪ Have you been exposed to a lot of noise in your life?	❒	❒
▪ Have you had any trauma to the head?	❒	❒
▪ Do you have sinus or allergy problems?	❒	❒
▪ Are you experiencing dizziness (vertigo) and/or nausea?	❒	❒
▪ Has your hearing changed suddenly within the past 90 days?	❒	❒
▪ Do you currently have ear pain?	❒	❒
▪ If you are experiencing hearing loss, was the onset sudden or gradual?	Sudden❒	Gradual❒
▪ In which ear do you hear better from?	Same ❒ Left ❒	Right ❒
▪ What do you believe caused your hearing problem?_____		
▪ Do you wear hearing aids? If so, please check:	Both ears ❒ Left ❒	Right ❒
▪ Why have you decided to have your hearing tested at this time?		
❒ I feel my hearing is poor and may need to be aided.		
❒ Family/friends have suggested I have my hearing checked.		
❒ Other reason: _____		

Check all that apply:

☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Arthritis ☐ Diabetes
☐ Kidney Disease ☐ Cancer ☐ Measles ☐ Mumps ☐ Meningitis
☐ General Anesthetic

Current Medications: _____

	YES	NO
▪ Do you have difficulty hearing in quiet environments?	❒	❒
▪ Do you have difficulty hearing in noisy environments (e.g. restaurants)?	❒	❒
▪ Do you have difficulty hearing television or find you have to turn it up louder than others?	❒	❒
▪ Do you have difficulty hearing on the telephone?	❒	❒
▪ Do you have difficulty hearing female voices or children?	❒	❒
▪ Do you have difficulty hearing male voices?	❒	❒
▪ Does a hearing problem cause you to attend activities less often than you would like?	❒	❒

What is your goal and/or desired outcome from today's appointment?_____

_____

_____