HORAN & FEVOLD
Hearing Clinic, PLLC

Patient

Today's Date

1. Have you seen your primary doctor in the past 6 months?

YES NO

Additional Comments:

2. If yes, please fill in your primary doctors name:

3. Have you ever had a hearing test? If so, when and by whom? **(required)**

4. Do any of the following hearing concerns apply to you?

I have trouble hearing one-on-one conversation.

I have trouble hearing my spouse or family.

I have trouble hearing in noise (e.g. restaurants, groups, meetings).

I have trouble hearing on the telephone.

I have trouble hearing the television.

Additional Comments:

5. Do you have a family history of hearing loss?

YES NO

6. Have you been exposed to loud noise in your life?

YES NO

7. If yes, please describe your exposure (work, firearms, etc):

8. Check all symptoms that apply:

Pain in the ears
Feeling of pressure or fullness in the ears
Drainage from the ears
Deformity of one or both ears
Ear deformity
Dizziness or vertigo
Sudden loss of hearing in the past 90 days
Sudden onset of tinnitus (ringing in ear) in the past 90 days

9. Do you currently use tobacco?

YES NO

10. If yes, how often?

11. Do you have any medical conditions?

12. Please list current medications (or supply list in person).

13. What is your goal for today's appointment?