

Hearing Health Assessment

Patient Name _____ Date _____

General History

When was your last hearing exam? _____ By whom? _____

What were the recommendations? _____

How long ago did you notice a decline in your hearing?

Within past 90 days? 1-3 years 4-6 years 7-10 years 10+ years

Has anyone in your family suffered hearing loss? YES NO If yes, whom? _____

Do you have a history of:

Earaches YES NO Dizziness YES NO

Allergies to plastic YES NO Head Injury YES NO

Drainage YES NO Noise Exposure YES NO

ringing in ears YES NO PE Tube(s) YES NO

Pain/Discomfort YES NO Cerumen buildup YES NO

Excessive Noise Exposure YES NO

Medical History

Diabetes YES NO Radiation therapy to local area YES NO

Regular MRIs? YES NO Chemotherapy within 6 months YES NO

TMJ YES NO Compromised immune system YES NO

Allergies to any medications: _____

Current medications (i.e. blood thinners) _____

Have you ever had ear surgery? YES NO If Yes, which ear? LEFT RIGHT

Type _____

Please list other medical conditions: _____
