ADULT HEARING HISTORY

Name:_____ Age: _____ Date of birth: _____

□ Male □ Female Referred by: _____

Employer: _____ Occupation: _____

When did you first notice a hearing loss? _____

What do you think caused the hearing loss?_____

Which ear has the hearing loss? □ Right □ Left

Do you hear in close conversation? □ Yes □ No In groups? □ Yes □ No

Over the telephone? □ Yes □ No When there is background noise? □ Yes □ No

When did you last consult a doctor about your ears? _____

Who? _____

Earaches? □ Yes □ No Drainage? □ Yes □ No Which ear? □ Right □ Left

Any medical treatment of your ears?

_____

Have you ever had any head injuries? _____

Any history of exposure to intense noise? _____

Do any other members of your family have a hearing loss? □ Yes □ No

Who?_____

What serious illnesses have you had in the past? _____

Have you experienced periods of dizziness? _____

Do you have any ringing or other noise in your ears? _____

Are you taking medications? _____

*Additional information on reverse side

ADDITIONAL INFORMATION

Have you ever worn a hearing aid? □ Yes □ No Make: _____ Model:_____

Explain any difficulties you have in using your hearing aid: _____

_____

What is your reason for coming to the Hearing Health Center?

_____

_____

How did you hear about our services?

□ Doctor Referral □ Yellow Pages □ School □ Friend □ Advertisement

□ Previous Patient □ Other _____

Authorization for Release of Information

I authorize the Hearing Health Center of 1200 E. Michigan Ave. Suite 330, Lansing MI 48912 to release any part or all of my records to the following agencies and professional persons:

Name: **Address:**

Signature: _____

Relationship to Patient: _____

Date: _____