Hearing Health and History Form

Riddle Hospital
Main Line Health®

Patient Name:_____ **DOB:** _____

Reason for visit: _____

Do you perceive the hearing in one ear to be worse?: Right Left Equal

Do you have tinnitus? (ringing, buzzing, humming): Right Left Both

Have you had your hearing tested before? If so, when/where? _____

Do you perceive a decline in your hearing since your last evaluation? Yes No Unsure N/A

Have you ever/do you currently wear hearing aid(s)?: Yes No

Which areas do you experience most hearing difficulty (Circle all that apply)
One on one conversations TV Background noise Phone

Work Church/Religious services Other: _____

Ear Symptoms

Have you had vertigo/dizziness? If yes, describe symptoms and time of occurrence(s): _____
_____

In the last 90 days have you had any of the following symptoms? (Circle all that apply)

Pain/Discomfort: Right Left Both **Pressure/Fullness:** Right Left Both

Drainage: Right Left Both **Sudden Hearing Loss:** Right Left Both

Ear History

Please answer the following questions with as much detail as possible including which ear and time of occurrence.

Have you ever had ear infections/surgery? (Including childhood) _____

Do you have a history of exposure to loud noise? (firearms, tools/lawn equipment, music, etc.) _____
_____

Does anyone in your family have hearing loss? If so, who?:_____

Have you ever been to an Ear, Nose and Throat physician (ENT)?: Yes No
When/for what reason?_____

Other Relevant Medical History (Circle all that apply)

Head Injury High blood pressure Diabetes Cancer Measles/Mumps

Autoimmune Disease Alzheimer's/Dementia Arthritis/Neuropathy Vision problems