MY HEARING CENTERS
We Change Lives Through Better Hearing

MEDICAL HISTORY FORM

FOR OFFICE USE ONLY

Sycle ID: _____ Date: _____/_____/_____

Patient Name:_____ Date of Birth: _____/____/_____
(First) (MI) (Last)

Do you have pain/discomfort in your ear(s)? Yes: _____ No: _____
Do you have any drainage in your ear(s)? Yes: _____ No: _____
Have you had a sudden or rapid loss of hearing in the past 90 days? Yes: _____ No: _____
Do you have ringing or other noises in your ear(s)? Yes: _____ No: _____
Do you have acute or recurring dizziness or vertigo? Yes: _____ No: _____

Have you seen your physician regarding any of the above? If so, when? _____
Have you ever had ear surgery? Yes: _____ No: _____

Hearing History:

When was the first time you noticed difficulty hearing? _____

Have you had your hearing tested before? Yes: _____ No: _____ When: _____ Results: _____

In which ear is your hearing the worst? Right: _____Left: _____Same: _____
Have you noticed that people seem to mumble? Yes: _____ No: _____
Do you find yourself asking people to repeat what they have said? Yes: _____ No: _____
Do you sometimes hear words but do not always understand them? Yes: _____ No: _____
Do you find it difficult to hear in noisy places? Yes: _____ No: _____
Have you been told that you speak loudly? Yes: _____ No: _____
Have you been told that you turn the volume on TV up too loud? Yes: _____ No: _____
Do you have strain to understand young children's voices? Yes: _____ No: ____
If hearing loss is diagnosed, are you ready for help? Yes: _____ No: _____

Complete the following if you currently have a hearing aid:

How often do you wear your hearing aid(s)? _____ How old is/are your hearing aid(s)? _____

Style of hearing aid(s): _____ Brand: _____ Cost: _____

Do you wear hearing aids in both ears Yes: _____ No: _____
Where were you fit with the hearing aid(s)? _____
When wearing your hearing aid(s), do you have difficulty understanding in crowds? Yes: _____ No: _____
Do your hearing aids make your ears sore? Yes: _____ No: _____
Do your hearing aids whistle? Yes: _____ No: _____
Do you repair your hearing aids often? Yes: _____ No: _____
What is the greatest problem with your hearing aids? _____
On a scale of 1 to 10, rate your satisfaction level with your hearing aids (1=Poor, 10=Excellent): _____