ADVANCED HEARING
AND BALANCE CENTER

Name: _____ Date of Birth: ___/___/___ Today's Date: ___/___/12

Reason for Today's visit _____

Referred by _____

GENERAL MEDICAL

1. Have you had any of the following:

Kidney Disease……..YES	NO		Hypertension……YES	NO	
Diabetes……YES	NO		Visual problems……...YES	NO	
Cancer……YES	NO		Sinus problems…….YES	NO	

Other (please list)_____

2. Are you taking any **medications**? YES NO
IF YES, which ones_____

3. Have you ever experienced **head trauma**? YES NO
4. Have you ever had surgery on your ear(s), nose, or throat? YES NO

HEARING (*Please fill in the blanks or circle where appropriate*)

1. When did you **first** notice your hearing problem? _____

2. Was your **change in hearing** SUDDEN or GRADUAL ?

3. Has your hearing become **worse** since you first noticed the problem? YES NO

4. Do you hear **better in one ear** than the other? YES NO
If **YES**, which ear is **better**? RIGHT LEFT

5. Does your hearing remain CONSTANT or FLUCTUATE?

6. Have you experienced any of the following:

YES	NO	**Ear pain**	**If Yes:**	RIGHT	LEFT	BOTH
YES	NO	**Plugged ear(s)**	**If Yes:**	RIGHT	LEFT	BOTH
YES	NO	**Ringing/buzzing**	**If Yes:**	RIGHT	LEFT	BOTH
YES	NO	**Dizziness/Vertigo**				

8. Have you ever been exposed to loud noise (work, recreation, Military service)? YES NO
IF YES, please briefly explain_____

9. Has anyone in your family experienced hearing loss? YES NO
If YES, who? _____

10. Have you had your hearing tested before? YES NO

11. Have you ever worn hearing instruments? YES NO Currently? YES NO

12. Which situations do you have difficulty hearing? _____