PORTAGE VALLEY HEARING

HISTORY

Name _____ Today's Date_____

Reason for today's visit (one sentence or less) _____
_____

Brief history of the problem _____
_____

Please check all that apply

- ❑ Hearing loss Right ear Left ear Both
- ❑ Currently wear hearing aids Right ear Left ear Both
- ❑ Tinnitus (noise in ears) Right ear Left ear Both
- ❑ Wax Build up Right ear Left ear Both
- ❑ Chronic ear infections Right ear Left ear Both
- ❑ Perforated ear drum Right ear Left ear Both
- ❑ Ear surgery Right ear Left ear Both
- ❑ Dizziness Spinning Off-balance Lightheaded Spaciness
- ❑ Noise exposure Machinery Gunfire Loud Music Explosion
- ❑ Family history of H. loss None List: _____

Medical and Social History

Please list any allergies to medicines, latex, ear molds, etc. _____
_____

Current Medications _____
_____

Medical Conditions _____
_____

Have you ever received Chemotherapy treatments? _____ If yes, list medications ___
_____

Occupation (If retired, list past occupations) _____
_____

If hearing instruments were recommended would consider using them? _____