PVH
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? _____