**Name**_____**Date**_____

## MEDICAL HISTORY

Have you seen a Doctor specializing in the disease of the Ears in the last six months_____**Yes/No**

If Yes Dr.'s Name and date and reason_____

_____

Have you had any type of ear surgery?_____**Yes/No**

If Yes When?_____by Whom?_____

What type of Surgery?_____

Have you ever had your hearing tested?_____**Yes/No**

If Yes When?_____by Whom?_____

What were the findings and/or recommendations?_____

_____

## ABOUT YOUR EARS

Deformity of the ear?_____**Yes/No**

Hearing loss in one ear in the last 90 days?_____**Yes/No**

Do you have any pain in your ears?___**Yes/No**

Have you ever seen a doctor for wax removal?_____**Yes/No**

Sudden or long term dizziness?_____**Yes/No**

Drainage from either ear in the past 90 days?_____**Yes/No**

Sudden or rapid hearing loss in the past 90 days?_____**Yes/No**

Buzzing/Ringing/Tinnitus?_____**Yes/No** If **YES** one ear or both?_____

## ABOUT YOUR HEARING

Do you feel you have difficulty hearing?_____

Do you feel one ear is better?_____

***Do you experience difficulty with…..***

Understanding all the words in conversation clearly.....**Yes/No**

Hearing in a crowd or other noisy situations where background noise is present....**Yes/No**

Hearing on the telephone…..**Yes/No** Which ear do you use on the telephone?.....**Right/Left**

Do you now or have you ever worn hearing instruments?.....**Yes/No**

What type/brand_____

How did you do with the hearing aids? _____

In what situations does your hearing problem give you the most trouble? _____

_____

_____