Adult Hearing History

Today's Date______/______/______

Name____ D.O.B.______/______/______ Age______

Address____ Sex: Male☐ Female☐

City____ State____________ Zip______________

Email____

Accompanying Party Name____ Relationship____________

Telephone: Work________________________________ Home__________________________________

Current Occupation___________________________ Referred by_________________________________

Health Insurance____________________________________ | ___________________________________

Company Name — Member Number

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Have you ever had a hearing test? Yes☐ No☐ If Yes, When___________ Where____________________

Have you ever had Surgery on your ears? Yes☐ No☐ If Yes, Explain____________________________

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Do you have a hearing problem? Yes☐ No☐ If Yes, is it: Mild☐ Moderate☐ Severe☐

How long have you had the loss?___________ Is your hearing loss fluctuating? Yes☐ No☐

Do you have a history of sudden or rapidly progressive hearing loss within the previous 90 days? Yes☐ No☐

If you responded Yes to the above question, is your sudden hearing loss: Right Ear☐ Left Ear☐ Both Ears☐

Which ear do you have greater difficulty hearing? Right☐ Left☐ Unsure☐

Do you have trouble hearing in any of the following situations?

Telephone	Yes☐	No☐	Men talking	Yes☐	No☐
At social gatherings	Yes☐	No☐	One on One talking	Yes☐	No☐
Background noise	Yes☐	No☐	Women talking	Yes☐	No☐
Television	Yes☐	No☐	Other (please list)____________________		

Are you currently taking any prescription or nonprescription drugs? Yes☐ No☐ For what…?

Please list____

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Present Symptoms / Do you have:

Noises/Tinnitus in your ears? Yes☐ No☐ If Yes: Right☐ Left☐ Both☐ Is it: Constant☐ Periodic☐

Do you have ear pain, or discomfort? Yes☐ No☐ Right☐ Left☐ Both☐

Any history of, or active drainage from the ears within the previous 90 days? Yes☐ No☐

Do you have a history of ear infections? Yes☐ No☐

Do you currently have: Nausea☐ Headaches☐ Chronic Dizziness/Vertigo☐

Have you fallen in the last year? Yes☐ No☐ List how many times and when_____________________

New Way Hearing™

Adult Hearing History

Primary Doctor's Name______________________________

Doctor's Office Location______________________________

Are you currently being treated by this Primary Dr., or another Dr. for ear problems of any kind? Yes☐ No☐

If yes, Explain______________________________

May we have permission to contact your doctor(s) to send your Audiologic Records*: Yes☐ No☐

If Yes, Please Sign **X**______________________________

(*Includes Your Audiologic Report & Audiogram)

Have you ever been exposed to excessive noise levels without hearing protection: Yes☐ No☐

Where? Job☐ Military☐ Recreation☐ (i.e., music☐ firearms☐ motorcycles☐ aircraft☐ power tools☐), Other:______________________________

Do you have, or have you had:

☐Diabetes	☐Hypoglycemia (low blood sugar)	☐Vertigo (spinning)
☐Imbalance	☐Other dizziness	☐High blood pressure
☐Low blood pressure	☐History of migraines	☐Heart disease
☐Kidney disease	☐HIV or Aids	☐High fever
☐Stroke	☐Serious head trauma	☐Falling experiences

To your knowledge, have you ever received: *Intravenous Antibiotics*: ☐Yes ☐No *Quinine:* ☐Yes ☐No

Chemotherapy: ☐Yes ☐No *High dose Vicodin:* ☐Yes ☐No *High dose Aspirin:* ☐Yes ☐No

Do you have any family member(s) with hearing loss? ☐Yes ☐No Who?______________________________

When did the family member(s) lose hearing? ☐Birth ☐Mid-life ☐Late-onset

Do you now, or have you ever worn a hearing aid? ☐Yes ☐No If Yes? ☐Right ☐Left ☐Both

Year____________Make______________________________Model______________________________

Is it satisfactory? ☐Yes ☐No If Not, why?______________________________

Have you performed any research on hearing aids? ☐Yes ☐No If Yes, explain______________________________

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What do you expect to gain from your visit to New Way Hearing™ today?______________________________

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(THIS SECTION IS FOR OFFICE PERSONAL ONLY)

Visible congenital or traumatic deformity to the ear(s)? ☐Yes ☐No

Audiometric air-bone gap equal to, or greater than, 15dB at 500Hz, 1000Hz, and 2000Hz? ☐Yes ☐No

Comments/Observations______________________________

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PCC______________________________ HCP______________________________