

## Erie Audiology, Inc. Health History Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### A. Hearing History (CIRCLE APPROPRIATE ANSWER)

- \* Yes No Do you have difficulty hearing? If yes, for how long? \_\_\_\_\_
- \* Yes No Is one ear better than the other? If yes, which one? \_\_\_\_\_
- \* Yes No Do any of your blood relatives have hearing loss? If yes, who? \_\_\_\_\_
- \* Yes No Do you have a history of ear infections?
- \* Yes No Do you have any pain, pressure, or fullness in your ears?
- \* Yes No Have you ever had ear surgery? If yes, please describe \_\_\_\_\_
- \* Yes No Have you been exposed to loud noise? If yes, when/what type? \_\_\_\_\_

### B. Dizziness/Imbalance History (CIRCLE/CHECK APPROPRIATE ANSWER)

- \* Yes No Do you have dizziness, vertigo or unsteadiness? If NO, move to the next section.

Choose one of the following that best describes your dizziness:

- A sensation of movement of the room: spinning, tilting or wave like movements
- Lightheadedness or feeling like you are going to faint
- Loss of balance or equilibrium

- \* Is the dizziness: Constant, all day long \_\_\_\_\_ In episodes or attacks \_\_\_\_\_
- \* Yes No Does your hearing change/fluctuate when the dizziness occurs?
- \* Yes No Have you ever had a medical evaluation or treatments for your dizziness?  
If yes, explain: \_\_\_\_\_
- \* Yes No Have you ever been diagnosed with a head or neck injury?  
If yes, explain: \_\_\_\_\_
- \* Yes No Have you ever had a seizure, mini stroke or been diagnosed with multiple sclerosis?

### C. Tinnitus History (CIRCLE APPROPRIATE ANSWER)

- \* Yes No Do you have noise(s) in your ears or head? If yes, for how long? \_\_\_\_\_
- \* Is the noise: **Constant** Pulsating **Low Pitch** High Pitch **Ringing** Humming?
- \* Yes No Is the tinnitus distressing or distracting for you? If yes, please describe \_\_\_\_\_

### D. Communication Requirements (CIRCLE APPROPRIATE ANSWER)

- \* Where do you live? **Own home** Assisted residential facility **Apartment** With family **Alone**
- \* Active in: **Church** Volunteer group(s) **Work** Social groups/clubs **Meetings/business groups**
- \* Do you: **Eat in restaurants** Travel **Use a computer/internet** Attend concerts, lectures, etc
- \* Do you have difficulty: **Hearing in noisy places (restaurants, etc.)** Hearing the TV  
**Hearing family members** Hearing women's/children's voices
- Other \_\_\_\_\_

*Other Side →*

**E. Telephone Requirements (CIRCLE APPROPRIATE ANSWER)**

- \* Which type of phone do you regularly use? **Home Phone** Cell Phone **Work Phone**
- \* If you regularly use a cell phone, what is the make, model, and age of the phone? \_\_\_\_\_
- \* What specific difficulties are you having on the phone? \_\_\_\_\_

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- \* Do your phone(s) have a volume control and/or speaker options? \_\_\_\_\_
- \* Do you have a computer and internet/Wi-Fi in your home? \_\_\_\_\_

**F. Medical History (CHECK /CIRCLE ANY CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST)**

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies                        | <input type="checkbox"/> Facial Numbness                       |
| <input type="checkbox"/> Alzheimer's/Dementia             | <input type="checkbox"/> Heart Surgery/Attack/Disease          |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Hepatitis                             |
| <input type="checkbox"/> C Diff                           | <input type="checkbox"/> High Blood Pressure                   |
| <input type="checkbox"/> Chemotherapy/Radiation Treatment | <input type="checkbox"/> Kidney Disease                        |
| <input type="checkbox"/> Circulation Problems             | <input type="checkbox"/> Mental Health Disorder                |
| <input type="checkbox"/> Dental Problems/TMJ              | <input type="checkbox"/> Neurological Disorder                 |
| <input type="checkbox"/> Depression                       | <input type="checkbox"/> Pacemaker                             |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Short-Term Memory Problems            |
| <input type="checkbox"/> Double/Blurred or Low Vision     | <input type="checkbox"/> Thyroid Disease                       |
| <input type="checkbox"/> Ear Injury                       | <input type="checkbox"/> Weakness or numbness in fingers/hands |

**Current/Past Medications**

Name of Medication	Dosage	Duration	Purpose

\* please attach a list if more space is required \*

- \* Yes No Are you allergic to any medications?  
If yes, please list: \_\_\_\_\_
- \* Yes No Are you allergic to latex?
- \* Yes No Are you allergic to acrylic?
- \* Yes No Are you allergic to silicone?

**Please send a copy of my diagnostic test results to my other health care provider(s). Yes No**

- 1) Signature of PATIENT or GUARDIAN **X** \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_  
**Annual update confirmation signature**
- 2) I have reviewed and updated the Health History Form **X** \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_
- 3) I have reviewed and updated the Health History Form **X** \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_
- 4) I have reviewed and updated the Health History Form **X** \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_
- 5) I have reviewed and updated the Health History Form **X** \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_
- 6) I have reviewed and updated the Health History Form **X** \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_
- 7) I have reviewed and updated the Health History Form **X** \_\_\_\_\_ Date \_\_\_\_\_ Provider \_\_\_\_\_