Erie Audiology, Inc. Health History Form

Name:_____ Date:_____

I. Hearing History

Do you have difficulty hearing? No Both Ears Right Ear Left Ear

Does one ear seem to have better hearing than the other? Yes No If yes, which one is better? _____

How long have you had hearing problems? _____

Do any of your blood relatives have hearing loss? No Yes Who?_____

Have you ever had ear surgery? No Yes Describe:_____

Do you own hearing instruments? No Yes How old are they?_____

Have you been exposed to loud noise? No Yes When/What type?_____

Do you have any pain, fullness or pressure in your ears? No Yes

Do you have a history of ear infections? No Yes

II. Dizziness/Imbalance History

Do you have dizziness, vertigo or unsteadiness? No Yes (If NO, move onto 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_____

Does your hearing change when the dizziness occurs? No Yes Explain:_____

Have you ever had medical evaluation or treatments for your dizziness? No Yes Explain:_____

Have you ever been diagnosed with a head or neck injury? No Yes Explain: _____

Have you ever had a seizure, mini stroke or been diagnosed with multiple sclerosis? No Yes

III. Tinnitus (head noise) History

Do you have noise in your ears or head? No Yes How long has this been a problem?_____

If yes, describe the noise: Constant Periodic Pulsating Low pitch High pitch Ringing Humming

Is tinnitus distressing or distracting for you? No Yes Please describe:_____

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IV: Overall Health History- Please mark ALL of the health issues that apply to you:

Double or blurred vision	Chemotherapy/ Radiation treatment	Diabetes	Weakness/numbness or stiffness in the arms/ hands/ fingers
Paralysis/Stroke	Dementia/ Alzheimers	Depression	Thyroid Disease
Facial numbness	Circulation problems	Cancer	High blood pressure
Pacemaker	Heart surgery/attack/disease	Allergies	Short-term memory problems
Neurological disorders	Mental health disorder	Dental Problems/ TMJ	Ear Injury

If you marked any of these conditions, or are experiencing others, please specify here:_____

_____

V. Communication Requirements

Do you live: In your own home In an assisted residential facility In an apartment With family Alone

Are you active: In church As a volunteer At work In social groups/ clubs In meetings or business groups

Do you regularly: Eat in restaurants Travel Use a computer/internet Attend concerts, musicals, lectures, etc

Do you have difficulty: Hearing in noisy places (restaurants) Hearing the television
Hearing family members Hearing women's or children's voices

Other_____

_____

VI. Telephone Requirements

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? _____

_____

Do your phone(s) have volume control and/or speaker options?_____

If so, do you know how to use them?_____

Do you have a computer and internet in your home?_____