The American Institute of Balance
Audiology Affiliate

HEARING SOLUTIONS

Name: ____ Date: _______________

MEDICAL DOCTOR INFORMATION

Referring Dr.: ____________________________ Phone: ( ) _______-_____________

Address: _________________________________ Suite: ___________

City: ____________________ State: ______ Zip Code: ____________

Family Dr: ______________________________ Phone: ( ) _______-__________

MEDICAL HISTORY

Chief Complaint(s): (check all that apply)

____ Hearing Loss (left / right/ both) ___ Tinnitus/Ringing ___ Dizziness

____ Other: (please explain) ____
____

Has your hearing been tested in the past? **Y N**

When ____________ Where __________________

Do you currently wear hearing aids? **Y N** Brand/year: __________________________

Are you satisfied with your hearing aids? **Y N** If not, please explain: ___________
____

If you notice hearing loss: (circle all that apply)

Do you feel it was gradual or sudden?
Do you have difficulties understanding TV, on the phone, or in the car?
Do you have difficulties understanding conversation in restaurants or groups?
Does it make you feel embarrassed, frustrated, or depressed?
Are you less inclined to go to religious services, restaurants, and parties?

Do you have a history of noise exposure? **Y N** If yes, please explain briefly: ___________
____

Do you have a family history of hearing loss? **Y N** If yes, who? What was the cause? _________
____

Have you had any medical problems with your ears? **Y N**

Please explain any chronic middle ear history or any ear-related surgeries: ___________
____

Have you experienced chronic or acute dizziness or vertigo in the last 90 days? **Y N**

If yes, please describe: _______________________________________

Please list medications you are taking: ______________________________________
____

Please list operations you have had: ____
____

Please list any medication you are allergic to or have been advised not to take: ____________
____

Please check any of the following you have had or now have:

☐Artificial Joints	☐ Cancer	☐ Heart Trouble/Disease	☐ Nausea
☐ Arthritis	☐ Circulation Problems	☐ Hepatitis/HIV	☐ Pacemaker
☐ Asthma	☐ Depression	☐ High Blood Pressure	☐ Parkinson's disease
☐ Back/Neck Problems	☐ Diabetes	☐ Infection/Wounds	☐ Ringing in ears
☐ Bell's Palsy	☐ Epilepsy/Convulsions	☐ Measles/Mumps	☐ Sinusitis
☐ Blood Disorders	☐ Glaucoma	☐ Meningitis	☐ Stroke/TIA
☐ Breathing Problems	☐ Head Injury	☐ Multiple Sclerosis	☐ Tuberculosis