EASTSIDE AUDIOLOGY
HEARING EXPERTS. SOUND ADVICE.

Patient History

Patient Name: _____ Birth Date:_____

Medical History:

Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, give date_____ Reason:_____
Yes No Have you ever had your hearing tested?
If yes, give date_____ By whom_____
Yes No Do you take medicine every day? If so please fill out "Medications Form".
Yes No Are you taking any blood thinners including aspirin?
Yes No Do you have diabetes?
Yes No Do you use tobacco products?
Yes No Do you have high blood pressure?
Yes No Do you have a heart condition? Yes No Do you have a Pacemaker?
Yes No Do you have any other medical conditions?
If yes please explain_____

About your Ears: Do you have any of these symptoms?

Yes No Deformity of the ear

Audiologist:

Yes No Do you have a history of ear infections? ***List of Medications received?***

Yes No Drainage from the ear **Yes No**
Yes No Sudden or rapid loss of hearing in the past 90 days?
Yes No Acute or chronic dizziness?
Yes No Do you have a better ear? If so which? Right Left
Yes No Have you ever seen a doctor for wax removal?
Yes No Do you ever have pain in your ears?
Yes No Do you experience ringing in your hear (tinnitus) Right Left Both
Yes No Do you have a history of noise exposure: If so explain_____

About Your Hearing: Do you experience difficulty with the following?

Yes No Understanding conversation
Yes No Hearing in a crowd
Yes No Hearing by telephone
Yes No Does anyone else in your family have a hearing problem?
What relationship?_____
How long have you had a hearing problem?_____
Yes No Do you now or have you ever worn a hearing aid?
If so how well does it meet your needs?_____

If amplification is appropriate, please prioritize in rank order from 1 (highest) – 3 (lowest):
____ Best Possible Hearing ____ Pricing ____ Cosmetics

What is your primary reason for coming here?
_____

Signature: _____ Date:_____