NAME_____

Date of Birth_____Today's Date_____

Medical History	YES	NO	NOT SURE
Do you have...			
Ear Pain?			
Blood or fluid drainage from the ear?			
Fullness or pressure in the ears?			
Ever had surgery inside the ears?			
Family History of hearing loss?			
History of loud noise exposure?			
Sudden or rapidly progressing hearing loss?			
Vertigo or Dizziness Problem?			
Have you had a balance problem or fall in the last year?			
Tinnitus (Ringing or buzzing) in the ears?			
A thyroid problem?			
Diabetes?			
High Blood pressure?			
High cholesterol?			
Have a pacemaker?			
Ever smoked?			
Are you on medications?			
On prescription blood thinners?			
Dementia or Alzheimer's?			
Problems with finger control or dexterity?			
Vision Problems?			
Depression or low mood?			

What are your goals for today's visit?

_____

_____

_____

_____

Please circle situations where you have trouble:

- ◊ One-on-one
- ◊ Meetings or lectures
- ◊ In restaurants
- ◊ On the phone
- ◊ Hearing the TV
- ◊ Live performances
- ◊ Religious services
- ◊ Soft voices
- ◊ Social situations
- ◊ Work or Career
- ◊ Bluetooth devices
- ◊ Music
- ◊ _____
- ◊ _____
- ◊ _____