Now Hear This® HEARING AIDS & AUDIOLOGY

Name: _____ DOB: _____ Date: _____

New Patient Medical History

What are your goals for today's visit? _____

How did you find out about us? _____

Yes	No	Please check Yes or No for the following:
		Have you previously had a hearing test? If yes, when? _____
		Have you ever had an ear surgery or ear infection?
		Have you noticed a change in your hearing in the last year?
		Have you ever had blood or drainage from your ear(s)?
		Are you experiencing ear pain, pressure, or fullness?
		Do you have sinus issues? Please explain: _____
		Have you been exposed to loud noise at any point in your life? Machine/ tools ___ Motorcycles ___ Firearms ___ Music ___ Other ____
		Does anyone in your family have hearing loss?
		Have you ever experienced vertigo or had balance issues?
		Have you had a fall in the past year?
		Do you wear, or have you ever worn, hearing aids?
		Do you experience Tinnitus symptoms? Right ___ Left ____ Both Ears ____ - What does it sound like? _____ Constant ___ Intermittent ___ - How bothersome are your Tinnitus symptoms? 1 ---------- 10 *Minimal* *Severe*
		Are you currently on any blood thinner medications?
		Do you have a history of smoking?
		Have you ever experienced a head trauma or traumatic brain injury (TBI)?
		Have you ever had an MRI or scan of your brain, face, and/or ears?

Please mark any that you have had or been diagnosed with:

___ Stroke
___ Cognitive Decline
___ Dementia
___ Diabetes
___ Bell's Palsy
___ Meniere's Disease
___ Acoustic Neuroma
___ Autoimmune Disease
___ Pneumonia
___ Tuberculosis
___ Lyme Disease
___ High Blood Pressure
___ High Cholesterol

Are you currently on any medications? If so, please list (or provide list):

HHIA Questionnaire

The purpose of this scale is to identify the problems your hearing difficulties may be causing you. Check **YES, SOMETIMES, or NO** for each question. Do not skip a question if you avoid a situation because of your hearing difficulty. If you use a hearing aid, please answer the way you hear **without** your device. Thank you!

		Yes	Some-times	No
	Does a hearing difficulty…			
S-1	…cause you to use the phone less?			
E-2	…make you feel embarrassed when meeting new people?			
S-3	…cause you to avoid groups of people?			
E-4	…make you feel irritated?			
E-5	…cause frustration when talking to family?			
S-6	…cause issues when attending a party?			
S-7	…impact your understanding of other people in the workplace or other daily activities?			
E-8	Do you feel handicapped by a hearing difficulty?			
S-9	…create issues with friends or family?			
E-10	…cause frustration when with people in the workplace or other daily activities?			
S-11	…impact your understanding in theaters?			
E-12	…cause you to be nervous?			
S-13	…cause you to visit friends or relatives less?			
E-14	…cause you to have arguments with family?			
S-15	…cause problems when listening to TV?			
S-16	…cause you to shop less than you would like?			
E-17	…upset you at all?			
E-18	…cause you to want to be by yourself?			
S-19	…make you to talk to your family less?			
E-20	Do you feel hearing difficulties limit your personal or social life?			
S-21	…cause issues when in a restaurant?			
E-22	…cause you to feel depressed?			
S-23	…cause you to watch less TV than you want?			
E-24	…make you feel uncomfortable when talking to friends?			

E-25	…make you to feel left out when with a group of people?			

Thank you for taking the time to complete this paperwork. Our Audiologist will be with you shortly!