

PREMIUM
HEARING SOLUTIONS
Hearing health care... The way it was meant to be.

Hearing Case History Form

Health History:

1. How's your vision (with correction)? _____
2. Do you have diabetes? _____ If yes, do you take medicine or insulin for it? _____
3. Are you on blood thinners? _____ If yes, what kind? _____
4. Do you have arthritis in the fingers? _____ If yes, would you describe it as mild?

Hearing History:

5. How long have you been having hearing difficulties? _____
6. Was the hearing loss sudden or gradual? _____
7. Which ear is your better hearing ear? Right, Left or Both the Same? _____
8. Do you hear ringing/any ear noises? If yes, describe. _____
9. Do you have dizziness or vertigo? _____
10. Have you ever had ear surgery? No _____ Yes _____. If yes, why and what was done? _____
11. What prompted you to have your hearing tested? _____

Amplification History (complete if have worn hearing aids in the past):

12. Which ear(s) did you wear it in? _____
13. What type did you wear? _____
14. Were you happy with your hearing aid(s)? If no, why not? _____

Telephone History:

15. Do you always hear the phone ring? _____
16. Do you have difficulty hearing over the telephone? _____
17. Which ear do you use on the telephone? _____

Occupational History:

18. What is your present occupation? _____
19. Do you now (or ever) worked in a noisy place? _____
20. Do you have history of any gunfire exposure? _____
21. Does your hearing loss cause you any problems in your occupation? _____ Describe.

22. Are you exposed to noise in any of your pastimes or hobbies? _____

Communication History:

23. Do you have trouble hearing in background noise (ie: restaurants)? _____
24. Do you have trouble hearing children? _____
25. Do you have problems hearing in church, synagogue, or a large lecture hall? _____
26. Can you hear conversation in the car? _____
27. If we find through the evaluation that you can be helped with amplification, are you ready for that help? _____ If no, why not? _____