Advanced Hearing Solutions

# Medical and Audiologic History

Name _____ Date _____

Family Physician _____

❒ Yes ❒ No Have you seen an Ear/Nose/Throat Physician?
Name _____ Date _____

❒ Yes ❒ No Have you had any type of ear surgery?
Surgery _____ Date _____

❒ Yes ❒ No Have you ever had your hearing tested?
By whom _____ Date _____

❒ Yes ❒ No Deformity of ear(s)

❒ Yes ❒ No Tinnitus/ringing in the ear(s)

❒ Yes ❒ No Have you ever seen a physician for wax removal?
How Often _____

❒ Yes ❒ No Is hearing the same in both ears?
Better hearing ear is your ❒ Left ❒ Right

❒ Yes ❒ No Family history of hearing loss?

❒ Yes ❒ No History of exposure to loud noises?

***Do you experience difficulty with any of the following?***

❒ Yes ❒ No Hearing by telephone

❒ Yes ❒ No Hearing in quiet

❒ Yes ❒ No Hearing in a crowd

❒ Yes ❒ No Hearing television or radio

❒ Yes ❒ No Do you now or have you ever worn hearing devices?
Manufacture/Style/Year _____

❒ Yes ❒ No Do you have any problems with your current devices?
If yes, please explain _____
_____