HOLLAND HEARING CENTER

Primary Concern:
☐ Hearing
☐ Tinnitus (ringing in the ear)

Adult Hearing and Balance History

Please Print

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ____

Please answer the following questions when applicable.

Do you think you have a hearing problem?

Right Ear: Yes____ No____

Left Ear: Yes____ No____

If so, how long have you had this problem?

Right Ear: _____

Left Ear: _____

Do you wear hearing aids?

Right Ear: Yes____ No____

Left Ear: Yes____ No____

If so, for how long? Right Ear: _____ Left Ear: _____

Have you had ear infections or ear surgery?

Right Ear: Yes____ No____

If yes, describe: _____

Left Ear Yes____ No____

If yes, describe: _____

Name of ear specialist: _____

Do you have a feeling of discomfort (pain, pressure, etc.) in your ears?

Right Ear: Yes____ No____

Left Ear: Yes____ No____

Describe:_____

History of noise exposure (occupational, recreational, military service)?

List all types of exposure: _____

Have any of your family members had significant hearing or balance problems?

Yes____ No____

If yes, please state the relationship and describe:_____

Do you have **ringing in your ear(s)** or other head noises **(tinnitus)**? Annoyance: Scale 1-10 ___

Right Ear: Yes____ No____

Constant: ____ Recurrent (comes & go's): ____

Left Ear: Yes____ No____

Constant: ____ Recurrent (comes & go's): ____

Describe:_____

Are you having any **dizziness** or **balance** problems? Yes____ No____

Describe:_____

When did your dizziness or imbalance first begin? _____

Do you feel this followed a significant event or illness? If yes, what happened?

_____

Is your dizziness constant or does it come and go? (Circle ONE)

If it comes and goes, how long does it typically last? ___seconds / minutes / hours

How often does it typically occur? ___ times per hour / day / week / month / year

What symptoms best describe how you feel or felt (i.e. hearing loss, nausea, ear fullness or pressure, tinnitus) when dizzy? Does anything cause your dizziness to lessen?

_____

Please list all medications you are currently taking. If you have a list we would be happy to copy it: _____

_____

It is not unusual to find hearing loss in conjunction with the following health conditions, please indicate all that apply:

___ Smoke cigarettes ___ Diabetes ___ Heart disease ___High blood pressure
___ Arthritis ___Depression ____Memory changes ___Low vision ___Pacemaker

Why did you make this appointment?
___Family/friend ___Physician ___Prior Experience
___Other (please comment): _____

Thank you for this information. Your provider will complete the rest of this form.

Provider's notes: _____

_____

_____

_____