

Hearing Health Assessment

Patient Name		Date
General History When was your last hearing exam?	U COLOR	By whom?
What were the recommendations?		The state of the s
How long ago did you notice a decline in your hearing?		
○ Within past 90 days ○ 1-3 years ○ 4-9 years	○ 7-10 y	rears
Do you smoke?	Yes	○ No
Have you ever used assistive listening devices?	Yes	○ No
Do you suffer from acute or chronic dizziness?	○ Yes	○ No
Has anyone in your family suffered hearing loss?		O No If yes, who?
Do you suffer from tinnitus?	○ Yes	O No If yes, which ear?
Medical History (please check all that apply)		
○ Diabetes ○ Radiation therapy to local area	s C	Compromised immune system
Cognitive ability Chemotherapy within 6 month	s C) TMJ
Allergies to any medications, plastics, etc?		
Current medications (i.e. blood thinners)		
		-
Have you ever had ear surgery? Yes	○ No	
Туре		
Do you have regular MRIs? Yes	○ No	
Please list all major surgeries and illnesses (past 10 year	s)	
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