______________________ ______________________ ___
LAST NAME FIRST NAME M.I.

Medical History about your Ears

- Have you seen an ear doctor within the last 6 months? YES NO
- Have you had your hearing tested recently? YES NO
  - If yes, when? _________
- Do you think you have a hearing loss? YES NO
- Did your hearing loss progress gradually? YES NO
- Do you have better hearing in your right or left ear? ___________
- Do other members of your family have hearing problems? YES NO
- Have you ever worn a hearing aid? YES NO
  - If yes, how long? ___________
- Do you have ringing or noises in your ears? YES NO
- Do you have dizzy spells or nausea? YES NO
- Have you had recent earaches, ear infections or ear discharge? YES NO
- Have you been exposed to high levels of noise? YES NO
- Have you ever had ear surgery? YES NO
- Are you currently using blood thinners? YES NO
- Do you have any major illnesses and/or infectious diseases? YES NO
  - If yes, please list…_____________