

**OLYMPIC HEARING CENTER
PATIENT DATA**

NAME: _____ DATE: ____/____/____
Month Day Year

BIRTHDATE: ____/____/____ AGE: _____ MALE FEMALE
Month Day Year

PRIMARY CARE PHYSICIAN: _____
REFERRING PHYSICIAN: _____
How did you hear about us: _____

MEDICAL/AUDIOLOGICAL INFORMATION

What are you here for today? _____

Please list conditions for which you are being medically treated: *(use back if needed)* _____

Please list all medications taken regularly: *(use back if needed)* _____

Please circle YES or NO and comment if appropriate)

History of ear infections	YES	NO	_____
Surgery on your ear	YES	NO	_____
Sudden hearing loss	YES	NO	_____
Which ear is best	Left	Right	_____
Tinnitus (ringing/buzzing in ear)	YES	NO	_____
Vertigo/Dizziness	YES	NO	_____
Ear pain or drainage	YES	NO	_____
History of noise exposure	YES	NO	_____
Chemotherapy/Radiation	YES	NO	_____
Head/Neck trauma or injury	YES	NO	_____
Family history of hearing loss	YES	NO	_____
Prior hearing testing	YES	NO	_____
Prior hearing aid use	YES	NO	_____

COMMUNICATION DIFFICULTIES

I notice hearing problems	YES	NO	_____
My family notices hearing problems	YES	NO	_____
I have difficulty with the telephone	YES	NO	_____
I have difficulty with the television	YES	NO	_____
I have difficulty in groups/crowds	YES	NO	_____
Do you hear certain voices/pitches better than others?	YES	NO	_____
Do you avoid social situations because of your hearing problems?	YES	NO	_____

Name: _____ Date _____

Specific Needs.

Please list 5 situations you have difficulty hearing. Be specific. Example "I don't hear the timer when cooking". "At the Rotary meeting I can't hear the speaker".

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