

CASE HISTORY

Alutiiq Hearing Services – Cindy Weber, Audiologist

Patient Name: _____ **Age:** _____ **Date:** _____

Your Main Concern today is:

___ **Hearing Loss:** ___ Right Ear ___ Left Ear ___ **Difficulty Hearing:** ___ In Quiet ___ In Noise

___ **Tinnitus/Ringing:** ___ Right Ear ___ Left Ear ___ **Telephone:** ___ Right Ear ___ Left Ear ___ **Dizziness/Vertigo**

How long have you noticed this difficulty? _____

Do you feel that your hearing is changing? ___ Yes ___ No ___ Gradual over time ___ Sudden loss

Have you been exposed to loud noise, either recently or in the past? ___ Yes ___ No

___ Airplanes or Aircraft Noise ___ Boats or Boat Engines ___ Hunting/Shooting ___ Power Tools ___ Music/Concerts ___ Military

___ Factory Noise ___ Farm Machinery ___ Other: _____

Have you seen an Ear, Nose, and Throat Physician? ___ Yes ___ No ___ If so when was your last visit _____

Name of the ENT Dr. you saw: _____

Have you ever had any ear surgery or surgery that may have affected your hearing? ___ Yes ___ No

Is there a history of hearing loss in your family? ___ Yes ___ No If so: Who? _____

Have you ever had an ear infection? ___ Yes ___ No ___ As a child ___ As an adult

Have you had any recent ear pain, drainage, pressure or fullness feeling in the ear/s? ___ Yes ___ No ___ Right ___ Left

In the past 10 years have you experienced chronic or acute dizziness, lightheadedness, or vertigo? ___ Yes ___ No

If yes, please describe: _____

Do you take any Aspirin or any blood thinners? ___ Yes ___ No What? _____ How often? _____

Please check off any of the following that you currently have or have had in the past:

___ Arthritis ___ Measles ___ Asthma ___ High Blood Pressure ___ Neurological Symptoms ___ HIV

___ Heart Trouble ___ Hepatitis ___ Sinusitis ___ Stroke/TIA ___ Meningitis ___ Diabetes ___ Head Injury

___ Parkinson's ___ Bell's Palsy ___ Loss of Sight ___ Cancer – Type _____

___ Radiation ___ Chemotherapy ___ Other _____

Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:

___ Improved Hearing in Quiet ___ Improved Hearing in Noise ___ Affordability ___ Cosmetic Appearance

If you are currently using a hearing aid, or have in the past, please answer the following:

Which ear was aided? ___ Right ___ Left How long have you used a hearing aid? _____