Ukiah Hearing Care

Hearing the Happy Sounds of Your Family

◆Patient Information◆

Patient Name: _____ Male____ Female____
Last First M

Street Address_____

Mailing Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Birthdate_____ Age_____ Soc. Sec. #_____

Work Phone_____ Employer_____ Occupation_____

Referred By_____

Primary Care Physician_____

Reason For Visit_____

◆Person Responsible For Account◆

Name_____ Soc. Sec. #_____

Mailing Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____

Employer_____

◆Insurance◆

Primary Insurance Coverage

Insurance Co._____

Subscriber_____

Group #_____

SSN# _____

Address_____

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Adult Hearing Health History

Patient Name: _____ BD: _____ Date: _____

I. Primary Symptom(s): _____

_____

II. Present Symptoms and Hearing Complaints:

Hearing Loss: Both Ears Right Only Left Only N/A

When did your hearing loss first begin? _____

Do you know what caused your hearing loss? _____

Has your hearing changed? (i.e. sudden, gradual, fluctuating) _____

Do you have a better hearing ear? _____

Hearing Aids: Both Ears Right Only Left Only N/A

Make: _____

Model: _____

Style: _____

Year: _____

Tinnitus (Noise in ears): Both Ears Right Only Left Only N/A

Describe the sound: _____

When did it first occur? _____

Is the sound constant or periodic? _____

If periodic, how often does it occur? _____

Is the sound distressing to you? If yes, describe: _____

Feeling of Fullness: Both Ears Right Only Left Only N/A

When did the fullness first occur? _____

Constant or periodic? _____

If periodic, how often does it occur? _____

Dizziness/Unsteadiness: None

Describe the symptom _____

When did it first occur? _____

Constant or periodic? _____

If periodic, how long does it last? _____

Ear Infections/Middle Ear Problems:	Both Ears	Right Only	Left Only	N/A

Describe condition: _____

Previous treatments? _____

III. In the last 90 days have you experienced:

Ear Pain:	Both Ears	Right Only	Left Only	N/A
Ear Discharge:	Both Ears	Right Only	Left Only	N/A
Sudden Change in Hearing:	Both Ears	Right Only	Left Only	N/A

IV. Have you seen a physician or ear specialist in the last six months? YES NO

Doctor's Names: _____

_____

V. Have you ever had any of the following physical conditions. Circle Yes or No and describe.

Middle Ear Infections _____	YES	NO
Ear Surgery _____	YES	NO
Skin tags on or near the ear _____	YES	NO
Holes or pits on or near the ear _____	YES	NO
Other ear malformations _____	YES	NO
Vision Loss _____	YES	NO
Difficulty seeing at night _____	YES	NO
Retinitis Pigmentosa (RP) _____	YES	NO
Eye Surgery _____	YES	NO
Two different colored eyes _____	YES	NO
White patch of hair _____	YES	NO
Cleft palate _____	YES	NO
Holes or cysts in neck _____	YES	NO
Heart defect _____	YES	NO
Kidney disease or infection _____	YES	NO
Arthritis _____	YES	NO
Diabetes _____	YES	NO
Patches of different colored skin _____	YES	NO
Bones that break easily _____	YES	NO
Fainting spells _____	YES	NO
Learning impairment _____	YES	NO
High blood pressure _____	YES	NO
Head injury/unconsciousness _____	YES	NO
Mumps _____	YES	NO
Scarlet Fever _____	YES	NO
Measles _____	YES	NO
Meningitis _____	YES	NO
Allergies _____	YES	NO
Other _____	YES	NO

VI. Please list all medications that you are currently taking:_____

_____

VII. Family History of Hearing Loss

Relation to you:

1._____

2._____

3._____

VIII. Noise History

Do you have any military experience? YES NO

Have you been exposed to noise in the past 14 hours? YES NO

If yes, did you wear ear protection during the entire noise exposure? YES NO

When in high noise areas, I use hearing protection: 0% (Never) 20% 40% 60% 80% 100% (Always)

Type of hearing protection used (brand and model)_____

Have you ever participated in any of the following? Circle those that apply.

Chain Saw | Dirt bike or loud RV | Firearms | Loud Music

Lawn Equipment | Wood Working Equipment | Other Noise Exposure_____

IX. Occupational Noise History (Employers where you were exposed to loud noise levels):

Employer	City	Duties	Length of Service	Ear Protection
1.				YES NO
2.				YES NO
3.				YES NO
4.				YES NO
5.				YES NO

X. Social History

Do you avoid social occasions because you have difficulty hearing? YES NO

Do you find yourself having to ask people to repeat themselves? YES NO

Do you sometimes hear words but do not understand? YES NO

Do you have difficulty understanding people in noisy places? YES NO

Have you been told that you speak loudly? YES NO

Do others complain of the TV being too loud? YES NO

Are some voices easier to understand than others? YES NO

Do you find loud sounds bothersome? YES NO

Describe your areas of primary hearing difficulty:_____

_____