CONTRA COSTA HEARING AID CENTER

Confidential Case History

Patient Name: _____ Spouse: _____

Address: _____

City: _____ State: _____ Zip: _____

Male ☐ Female ☐ Birth Date: _____

Phone Number: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Present Occupation: _____ Retired? YES ☐ NO ☐

Family Physician: _____ Phone Number: _____ City: _____

ENT Physician: _____ Phone Number: _____ City: _____

Referred by: _____

Did your occupation or other activities expose you to loud noise? ☐ Yes ☐ No

Describe the noise exposure _____

Preferred Language: _____ Other Languages Spoken: _____

How did you find out about our Center? _____

What are your reasons for scheduling this appointment? _____

What do you think may have caused your hearing problem? _____

Has your hearing changed since you first noticed a problem (e.g. improved or worsened) ?

_____

_____

_____

IF A HEARING LOSS IS DISCOVERED, ARE YOU READY FOR HELP? ☐ YES ☐ NO

Medical Waiver: I have been advised by the undersigned, that the Food & Drug Administration has determined that my best interest would be served if I had a medical evaluation by a licensed physician (preferably by a physician who specializes in diseases of the ear) before I purchase a hearing aid. I understand that the testing information herewith was communicated and am 18 years of age or older.

Signature _____ Date _____

Toby Hill _____ State License # HA-7306

_____ State License #

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Medical History

Are you presently under the care of a medical specialist (e.g. neurologist, ear-nose-throat (ENT) specialist) or other? ☐Yes ☐No

If yes, Please list each specialist's name and type of specialty:

_____

_____

Please list daily medication taken and for what:

_____

_____

Is there a history of hearing loss in your immediate family?

Please list relationship:

_____

When was your most recent hearing test, or will this be your first hearing test?

_____

Have you ever had any surgery on your ears? If so, please describe the surgery performed:

_____

(Please Circle One)

Will this be your first hearing test? YES NO

Have you been examined by a doctor in the past six months? YES NO

Have you ever had ear surgery? YES NO

Have you ever experienced any of the following:

1. Deformity of the ear? YES NO
2. Ear drainage in the past 90 days? YES NO
3. Sudden or rapid hearing loss in the past 90 days? YES NO
4. Sudden or rapid hearing loss in the past 90 days in one ear only? YES NO
5. Unilateral hearing loss of sudden or recent onset within the previous 90 days ? YES NO
6. Acute or reoccurring dizziness? YES NO
7. Have you had a doctor remove wax from your ears? YES NO
8. Are you experiencing ear pain now? YES NO

Which is your worst ear? Right Left Same

Tinnitus or ringing in your ears affects many people. Please answer the following:

Do you have any tinnitus symptoms? ☐Yes ☐No

When did you first notice it? ☐Recently ☐1-3yrs ☐4-10yrs ☐More than 10yrs

In which ear do you notice your tinnitus? Right Left Both

Have you been seen by a physician for evaluation and treatment your tinnitus? ☐Yes ☐No

Do you know the cause of your tinnitus? If so, please describe:

_____

What is your emotion toward your tinnitus? ☐Curious ☐Distressed ☐Concerned ☐Adaption

What else can you tell me about your tinnitus?

_____

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History of Hearing Loss

Do you sometimes hear conversations loud enough, but cannot understand the words? YES NO

Do you often ask others to repeat what they have just said? YES NO

Do you find it difficult to understand conversation in noise? YES NO

Do others notice you play the TV or radio too loud? YES NO

Do you have trouble understanding some people on the telephone? YES NO

How many years have you experienced hearing and understanding difficulty? _____

Do you currently wear hearing aids? YES NO

If so, how old are your current aids? _____

Which ear do you normally use on the telephone? Right Left

Have you ever avoided a social situation because you cannot hear? Describe the situation.

_____

_____

Does trying to hear cause you to be fatigued or frustrated? YES NO

Can you hear car horns, sirens, smoke alarms? YES NO

Have you ever used hearing aids in the past? YES NO

If so, what did you like about the hearing aid(s)?

_____

What did you not like about the hearing aid(s)?

_____

Is there anything else that you would like us to know?

_____

OTOSCOPIC EXAM AND HEARING TEST COMMENTS

CANALS:	**AS**	**AU**	**AD**	**SUP/ANT**	**SUP/POS**	**INF/ANT**	**INF/POS**
Normal							
Occluded							
Mild Wax							
No Wax							
Exostosis							

Tympanic Membrane:

Unremarkable

Sclerotic

Monomeric Spot

Retraction Pocket