Allegany Hearing & Balance, LLC

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Case History

Name: ____ **Date:** _____/_____/_______

Why did you decide to have your hearing tested? ________________________________

Where did you hear about our office?

□ Physician □ Yellow Pages □ Newspaper □ Friend □ Radio □ Other ____________________

Is there a known hearing loss? □ Yes □ No If yes, please describe: ________________

Did your hearing loss develop gradually or suddenly? ________________________

Which do you think is your better ear? □ Right □ Left

What do you think caused your hearing loss? ________________________________

Have you had surgery on your ears? □ Yes □ No If yes, what type? ________________

Which Ear: □ Right □ Left When? ________________ Treating Physician: ________________

Do you have dizzy spells or balance problems? □ Yes □ No

Do your ears feel stuffy or clogged? □ Yes □ No

Do you have head noise? (i.e. ringing) □ Yes □ No

If yes, please describe: ____

Does anyone in your family have hearing loss? □ Yes □ No Relative: ________________

Do you have difficulty hearing in noisy areas? □ Yes □ No

Do you have difficulty understanding conversation? □ Yes □ No

Does your family complain about the TV being too loud? □ Yes □ No

Do you own/wear a hearing aid? □ Yes □ No If so, for how long? ________________

Do you have or have you had any of the following?

□ Ear Infections □ High Blood Pressure □ Migraines □ Stroke □ Diabetes

□ Allergies □ Measles/Mumps □ Head Injury □ Seizures

□ Heart Disease/Surgery – Type: ____

Have you ever been exposed to excessive noise at home or work? □ Yes □ No

What was the noise? ____

Office Use Only

Otoscopy: AD: ____

AS: ____

Comments:

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