Erie Audiology, Inc. Health History Form

Name:_____ **DOB:**_____ **Date:**_____

A. Hearing History (CIRCLE APPROPRIATE ANSWER)

* Yes No Do you have difficulty hearing? If yes, for how long?_____
* Yes No Is one ear better than the other? If yes, which one? _____
* Yes No Do any of your blood relatives have hearing loss? If yes, who? _____
* Yes No Do you have a history of ear infections?
* Yes No Do you have any pain, pressure, or fullness in your ears?
* Yes No Have you ever had ear surgery? If yes, please describe _____
* Yes No Have you been exposed to loud noise? If yes, when/what type? _____

B. Dizziness/Imbalance History (CIRCLE/CHECK APPROPRIATE ANSWER)

* Yes No Do you have dizziness, vertigo or unsteadiness? **If NO, move to the next section.**

Choose one of the following that best describes your dizziness:

- A sensation of movement of the room: spinning, tilting or wave like movements
- Lightheadedness or feeling like you are going to faint
- Loss of balance or equilibrium

* Is the dizziness: Constant, all day long_____ In episodes or attacks_____
* Yes No Does your hearing change/fluctuate when the dizziness occurs?
* Yes No Have you ever had a medical evaluation or treatments for your dizziness?
  If yes, explain:_____
* Yes No Have you ever been diagnosed with a head or neck injury?
  If yes, explain:_____
* Yes No Have you ever had a seizure, mini stroke or been diagnosed with multiple sclerosis?

C. Tinnitus History (CIRCLE APPROPRIATE ANSWER)

* Yes No Do you have noise(s) in your ears or head? If yes, for how long? _____
* Is the noise: **Constant** Pulsating **Low Pitch** High Pitch **Ringing** Humming?
* Yes No Is the tinnitus distressing or distracting for you? If yes, please describe_____
  _____

D. Communication Requirements (CIRCLE APPROPRIATE ANSWER)

* Where do you live? **Own home** Assisted residential facility **Apartment** With family **Alone**
* Active in: **Church** Volunteer group(s) **Work** Social groups/clubs **Meetings/business groups**
* Do you: **Eat in restaurants** Travel **Use a computer/internet** Attend concerts, lectures, etc
* Do you have difficulty: **Hearing in noisy places (restaurants, etc.)** Hearing the TV
  Hearing family members Hearing women's/children's voices
  Other _____

Other Side →

E. Telephone Requirements (CIRCLE APPROPRIATE ANSWER)

* Which type of phone do you regularly use? **Home Phone** Cell Phone **Work Phone**
* If you regularly use a cell phone, what is the make, model, and age of the phone? _____
* What specific difficulties are you having on the phone?

_____

* Do your phone(s) have a volume control and/or speaker options? _____
* Do you have a computer and internet/Wi-Fi in your home? _____

F. Medical History (CHECK /CIRCLE ANY CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST)

- Allergies
- Alzheimer's/Dementia
- Cancer
- C Diff
- Chemotherapy/Radiation Treatment
- Circulation Problems
- Dental Problems/TMJ
- Depression
- Diabetes
- Double/Blurred or Low Vision
- Ear Injury
- Facial Numbness
- Heart Surgery/Attack/Disease
- Hepatitis
- High Blood Pressure
- Kidney Disease
- Mental Health Disorder
- Neurological Disorder
- Pacemaker
- Short-Term Memory Problems
- Thyroid Disease
- Weakness or numbness in fingers/hands

Current/Past Medications

Name of Medication	Dosage	Duration	Purpose

* please attach a list if more space is required *

* Yes No Are you allergic to any medications?
  If yes, please list: _____
* Yes No Are you allergic to latex?
* Yes No Are you allergic to acrylic?
* Yes No Are you allergic to silicone?

Please send a copy of my diagnostic test results to my other health care provider(s). Yes No

1) Signature of PATIENT or GUARDIAN **X**_____Date_____ **Provider**_____

Annual update confirmation signature

2) I have reviewed and updated the Health History Form **X**_____Date_____ **Provider**_____
3) I have reviewed and updated the Health History Form **X**_____Date_____ **Provider**_____
4) I have reviewed and updated the Health History Form **X**_____Date_____ **Provider**_____
5) I have reviewed and updated the Health History Form **X**_____Date_____ **Provider**_____
6) I have reviewed and updated the Health History Form **X**_____Date_____ **Provider**_____
7) I have reviewed and updated the Health History Form **X**_____Date_____ **Provider**_____