

FAMILY AUDIOLOGY ASSOCIATES, INC.
PATIENT CASE HISTORY FORM

Please answer the following questions:

YES NO

- Any active drainage from the ear within the last 90 days?
- Any history of sudden or rapidly progressive hearing loss within the last 90 days?
- Have you experienced any acute (recent) or chronic long term dizziness?
- Is there a sudden or recent onset of unilateral (one ear) hearing loss within the last 90 days?

Which is your best ear? Right Left Both the same

- Have you experienced any pain or discomfort in the ear?
- Have you received any medical or surgical treatment for hearing loss?
- Have you seen a physician regarding your ears? If so, who? _____
- Have you had any ear surgery? If so, when? _____
- Do you have allergies? If so, please list: _____
- What medications are you taking for any medical conditions?

- Do you take a blood thinner?
- Have you ever had a stroke or heart attack?
- Have you ever had a trauma or blow to your head?
- Have you ever been exposed to excessive noise?
- Do you have any ringing, noises, or sounds in your ears?
- Do any family members with hearing loss?
- Have you ever worn a hearing aid before? If so, when? _____
- May we have permission to send your results to your physician?

Signature: _____ Date: _____