DIVERSIFIED
Hearing & Balance Centers

Patient History

Name: ______________________ Birth date: ______________ Age: ______________

Referral source: ______________________ Date of follow up appointment: ______________________

Primary physician: ____

1. What is your primary complaint with your ears, hearing and/or balance? ______________________
   ____
   When did you first notice the problem(s) ______________________
2. Have you ever been to an ear, nose and throat doctor or an audiologist? ☐ Yes ☐ No
   If yes, who did you see and when? ______________________
3. From which ear do you hear better? ☐ Right ☐ Left ☐ Both the same
4. Do you have any idea what caused your hearing loss?
5. Has your hearing loss gotten worse over time? ☐ Yes ☐ No
6. Does your hearing fluctuate? ☐ Yes ☐ No
7. Is there a family history of hearing loss? ☐ Yes ☐ No If yes, whom: ______________________
8. Have you been exposed to loud noises recently or in the past?
   ☐ Firearms ☐ Music ☐ Factory work ☐ Power tools ☐ Other ______________________
9. Are you dizzy at times or do you have balance problems? ☐ Yes ☐ No
   If yes, please describe your symptoms. ______________________
10. Do you wear hearing aids? ☐ Right ☐ Left ☐ Both If yes, when did you purchase them? ______________

Do you have...	Right	Left	(For Audiologist Use Only)
Ear pain?			
Ear drainage?			
Fullness in the ears?			
Ringing in the ears?			

Please check all that apply

☐ Stroke ☐ Heart attack ☐ Visual problems ☐ Arthritis

☐ Head injury ☐ Aspirin therapy ☐ Diabetes ☐ High blood pressure

☐ Ear infections - date of last infection: ______________________

☐ Ear surgeries: ______________________

☐ Other medical conditions: ______________________

Please list all medications and dosage amounts: (list any additional on the back)

1. Medication: ______________________ Dosage: ______________
2. Medication: ______________________ Dosage: ______________
3. Medication: ______________________ Dosage: ______________
4. Medication: ______________________ Dosage: ______________

The above information has been provided to the best of my ability:

X: ______________________________ ______________

Patient signature Date

Audiologist's section

Ear deformities: R ______________________ L ______________________

Canal: Normal ☐ R ☐ L Occluding cerumen ☐ R ☐ L Some cerumen ☐ R ☐ L

Otorrhea: ______________________

Tympanic membranes: Normal ☐ R ☐ L Abnormalities: R ______________ L ______________

Facial nerve signs ☐ R ☐ L Other: ______________________

Audiologist ______________________ Date: ______________