GEORGIA HEARING CENTER

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MEDICAL HISTORY

Patient Name: Last_____ First_____ MI _____

What is your primary reason for today's visit? _____

Have you ever worn a hearing aid? _____

What type? _____

Do you experience any of the following?

- ❑ ringing, buzzing, roaring sounds in the ear?
- ❑ dizziness, loss of balance or vertigo?
- ❑ fullness in the ear?
- ❑ pain in the ear?
- ❑ numbness in the ear or face?
- ❑ family history of hearing loss?
- ❑ history of noise exposure (military, hunting, heavy equipment)?

How is your general health? _____

Are you a diabetic? _____ History of chemotherapy? _____

Do you wear a pacemaker? _____ Medications: _____

_____

_____

HEARING QUESTIONNAIRE

Please rate your hearing on a scale of 1 (poor) to a 5 (normal) for the following listening situations:

	POOR				NORMAL
Listening to T.V.	1	2	3	4	5
Listening in restaurants	1	2	3	4	5
Listening in groups/meetings	1	2	3	4	5
Listening on the phone	1	2	3	4	5
Listening in the car	1	2	3	4	5
Listening to a whisper	1	2	3	4	5
Listening to children's voices	1	2	3	4	5
Listening in quiet environment	1	2	3	4	5