BECKER AUDIOLOGY

Patient History

Name: _____ Today's Date: _____

Presenting Problem

1. Do you think you have a hearing problem? ☐ Yes ☐ No
2. If you have hearing loss, how long have you noticed this? _____
3. What do you feel is the cause of your hearing loss? _____
4. In which ear do you hear the best? ☐ Same ☐ Right ☐ Left
5. Do you have difficulty understanding:

   TV: ☐ Yes ☐ No Telephone: ☐ Yes ☐ No In groups: ☐ Yes ☐ No

History

1. Have you had your hearing tested before? ☐ Yes ☐ No
   a. If yes, when and where:_____
2. Have you had drainage from your ears within the past 90 days? ☐ Yes ☐ No
3. Have you had ear pain/discomfort within the past 90 days? ☐ Yes ☐ No
4. Have you ever experienced dizziness, imbalance, or falls? ☐ Yes ☐ No
5. Have you ever lost hearing in one or both ears ***suddenly***? ☐ Yes ☐ No
6. Have you ever had medical/surgical treatment for your ears? ☐ Yes ☐ No
7. Is there a history of hearing loss in your immediate family? ☐ Yes ☐ No
   a. If yes, who? _____
8. Do you have ringing or buzzing in your ears? ☐ Yes ☐ No
   a. If yes, which ear(s)? ☐ Both ☐ Right ☐ Left
9. Have you ever been exposed to loud noises? (Circle all that apply) Military Occupation Recreational
10. Have you ever worn hearing aids? ☐ Yes ☐ No
11. Have you ever had any of the following? (Circle all that apply)

Diabetes	Heart Problems	Cancer	Kidney Failure
Stroke	Meningitis	Head Injury	High Blood Pressure
Arthritis	Infectious Disease	Other: _____	

12. Medications: (Use back of paper if more space is needed): _____
    _____
    _____