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**www.hearingaidwv.com**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Chief Complaint: € Hearing Loss (€ Right ear/ € Left ear/ € Both) €Tinnitus/Ringing €Dizziness

€ Difficulty hearing (€ in quiet € in noise) € Telephone (€ Right Ear/ €Left ear/ € Both)

1. Do you think your hearing is changing? € Yes € No (€ Gradual € Sudden)
2. Have you ever been exposed to loud noise, either recently or in the past? € Yes € No

If so, please mark all that apply:

€ Farm Machinery € Music € Hunting/Shooting € Factory Noise

€ Power Tools € Military € Jet Engines € Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any of the following symptoms?

€ Deformity of the ear € Drainage of the ear € Ear Pain € Acute or chronic dizziness/Imbalance

€ Tinnitus (Ringing) € Sudden or rapid loss within the past 90 days

1. Have you ever had your hearing tested? € Yes € No If so, when was your last test? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you seen an Ear, Nose, and Throat Physician? € Yes € No

If so, who did you see? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had surgery that may have affected your hearing? € Yes € No

If yes, type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there a history of hearing loss in your family? € Yes € No If so, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you ever had an ear infection? € Yes € No If yes, € as a child € as an adult
3. Please check any of the following that you currently have or have had in the past:

€ Arthritis € Heart Trouble € Measles €Scarlet Fever

€ Asthma € Hepatitis € Meningitis € Sinusitis

€ Bell’s Palsy € High Blood Pressure € Mumps € Stroke/TIA

€ Diabetes € HIV € Neurological Symptoms

€ Head Injury € Malaria € Parkinson’s € Visual Trouble-Loss/Sight

1. Please rank the following in order of importance (1 being most important-4 being least important), if a hearing aid is recommended for you:

\_\_Improved hearing in quiet \_\_ Improved hearing in noise

\_\_ Cosmetic appearance \_\_ Expense

1. If you are currently using a hearing aid, or have in the past, please answer the following:

Which ear is/was aided? € Right € Left € Both

Have long have you been using a hearing aid? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_