Dr. Melissa Kipp Clark, Board Certified Audiologist/Gerontologist
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PATIENT INFORMATION

Name ____ Date _____________

Medical History:

Have you been examined by a doctor in the past 6 months?...................... YES NO
If yes, who?____
Will this be your first hearing test?.. YES NO
Have you had ear surgery?.. YES NO
If yes, when and what type of surgery ___________________________________
____

Do you have any of the following:
Family history of hearing loss?.. YES NO
Deformity of the ear? ………… YES NO………. If yes, Left Right BOTH
Sudden or rapid hearing loss in the past 90 days? ……………………… YES NO
Acute or recurring dizziness? ………………………………………………. YES NO
Ear pain? ………………………. YES NO ……… If yes, LEFT RIGHT BOTH
Recurring excessive cerumen (ear wax)?. YES NO .. If yes, LEFT RIGHT BOTH
Tinnitus (ringing or noises in the ears?.... YES NO .. If yes, LEFT RIGHT BOTH
Hearing Loss ……. YES NO … If yes, which ear is better, LEFT RIGHT EQUAL
If Yes, is/was the loss …………. GRADUAL FLUCTUATING SUDDEN
Fullness or Pressure in your ears?.... YES NO… If yes, LEFT RIGHT BOTH
Drainage? ……………………………… YES NO… If yes, LEFT RIGHT BOTH

HEARING HISTORY:

Have you noticed that people seem to mumble?... YES NO
Do you find yourself asking people to repeat?.. YES NO
Do you sometimes hear words but do not understand them?.................... YES NO
Do you find it difficult to hear in noisy situations?.................................... YES NO
Have you been told you speak loudly? ………………………………………. YES NO
Do others complain that you play the TV or radio too loud? …………….. YES NO
Do you find it difficult to hear when using the telephone? ………………… YES NO
Do you avoid social activities due to your hearing difficulty?.................. YES NO
Do your know the cause of your hearing loss? …………………………….. YES NO
If yes, explain____
____
Have you ever worn a hearing aid (s)?.. YES NO
If yes, how long and what type? ____
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What brings you here today?__________ My main concern (s) ________________

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