ADVANCED HEARING & BALANCE SPECIALISTS

www.TheHearingDocs.com

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617 E Riverside Dr #102, 435.688.8866
St. George, UT
1490 E Foremaster Dr #140, 435.656.5277
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52 S 850 West #103, 435.635.3689
Mesquite, NV
330 N Sandhill Blvd #F1, 702.346.4622
Overton, NV
475 N Moapa Valley Blvd, 702.397.8555
Cedar City, UT
1870 N Main Street #202, 435.867.0714
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1109 N 100 West, 435.438.6008
Fillmore, UT
374 S Hwy 99, 435.743.6323
Delta, UT
126 S White Sage Ave, 435.864.5995
Panguitch, UT
224 N 400 East, 435.676.8303

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Patient Name _____ **Age**_____ **Date:** _____/_____/_____

1. How can we help you / why are you here today? (please be specific) _____
_____

2. Do *you* feel you have trouble hearing people? ☐ Yes ☐ No
   If yes, how long ago have you noticed trouble? ☐ Recent ☐ 1-5 years ☐ 6-10 years ☐ More than 10 years
   In which ear is your hearing *poorest?* ☐ Right ☐ Left ☐ Not different
3. Do *other* people tell you that you have trouble hearing? ☐ Yes ☐ No
4. Do *you* feel you have trouble understanding people? ☐ Yes ☐ No
   If yes, in what places do you have trouble understanding? _____
5. Have you *ever* had a hearing evaluation? ☐ Yes ☐ No
   If yes, when was your last evaluation?_____ Where? _____
   What were the results? _____
6. Have you *ever* used hearing instruments/ assistive listening devices? ☐ Yes ☐ No
7. Do *you* feel you need hearing instruments/ assistive devices? ☐ Yes ☐ No
8. Any *sudden* changes in your hearing in the last 90 days? ☐ Yes ☐ No

Yes	No	
☐	☐	Do you have *frequent* dizziness or unsteadiness?
☐	☐	Do you have any drainage *recently* from the ear(s)?
☐	☐	Have you had any *recent* ear pain?
☐	☐	Do you have a family history of hearing loss/ problems?
☐	☐	Have you had *recent* feelings of fullness/pressure in your ears?
☐	☐	Do you have a history of ear infections?
☐	☐	Have you *ever* had exposure to loud noise?
☐	☐	Do you have a history of military service?
☐	☐	Have you *ever* used firearms?
☐	☐	Have you *ever* had ear surgery?
☐	☐	Do you have noises or ringing (tinnitus) in your ears / head?

Current medications, vitamins/supplements: _____

Please list all major surgeries: _____

Please list any serious illnesses: _____