History

BOUNTIFUL HEARING CENTER • PLLC

Name ____ **Date of Birth** ______________

Do you feel you have:

A casual Lifestyle? ☐ A busy and active lifestyle? ☐ Or somewhere in between? ☐

Do you often ask those around you to repeat themselves? ☐ Yes ☐ No

Do you often ***hear*** but just can't ***understand*** what's being said? ☐ Yes ☐ No

How long have you noticed a hearing loss? ______________

Have others mentioned that you aren't hearing them? ________ ☐ At home? ☐ At work?

In what situations do you have the most difficulty hearing? ________________________________

Do you have the following symptoms?

Yes	No		Right Ear	Left Ear
☐	☐	Difficulty in hearing?	☐	☐
		How long ago did this start? _________		
☐	☐	Fullness or stuffiness in ear?	☐	☐
☐	☐	Pain in ear?	☐	☐
☐	☐	Discharge in ear?	☐	☐

Have you experienced any of the following?

Yes	No		Right Ear	Left Ear
☐	☐	Injury to ears?	☐	☐
☐	☐	Ringing or buzzing in the ear?	☐	☐

How long? ____

Can you describe the noise? ____

Yes	No	
☐	☐	Do you have a history of loud noise exposure?
☐	☐	If you hunt, do you use hearing protection?
☐	☐	Do you ever experience dizziness? Please explain:

____

Please answer the following questions

Yes	No	
☐	☐	Do you wear hearing aids? How Long? _________ Are they helpful? ______________
☐	☐	Are you on Blood Thinners? What type? ____
☐	☐	Do you have an allergy to any drugs or food? If so, please list: ________________________________
☐	☐	Are you currently taking any medications or sprays? If so, please list: ________________________________
☐	☐	Do you currently have any significant illnesses? If so, please list: ________________________________

What is your main symptom or medical problem at this time?

____

Is your phone an: ☐ iPhone ☐Android

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