Chesapeake Hearing Center
(888) 647-6428
GENERAL HISTORY
PLEASE FILL OUT COMPLETELY

Name:_____Occupation (previous if retired):_____

Referred by: _____Reason for visit:_____

Please circle or fill in the proper response to all the following questions.

PREVIOUS HEARING EVALUATION: YES NO

Where:_____When:_____

Remarks:_____

HEARING LOSS: YES NO

Ear: Right Left Both Age at onset:_____

Progressive: YES NO

Fluctuating: YES NO

Family history of hearing loss: YES NO

Who:_____

Remarks:_____

EAR INFECTIONS: YES NO

Ear: Right Left Both Age at onset: _____

Drainage: YES NO

Pain: YES NO

Treatment: _____

Remarks:_____

EAR SURGERY: YES NO

Ear: Right Left Both

Date(s):_____

Type(s):_____

Remarks:_____

TINNITUS/HEAD NOISES: YES NO

Ear: Right Left Both

Describe:_____

Constant: YES NO

Fluctuate: YES NO

Remarks:_____

VERTIGO/SPINNING: YES NO

Spinning: YES NO

Light-headed: YES NO

Loss of balance: YES NO

Remarks:_____

HEAD INJURIES YES NO

Date(s):_____

Type(s):_____

Loss of consciousness: YES NO

Affected hearing: YES NO

Remarks:_____

ILLNESS (please circle below)

Diabetes Renal Infections Circulatory

Other:_____

MEDICATION(S):_____

_____

_____

DO YOU NOW OR HAVE YOU EVER

SMOKED TOBACCO: YES NO

How many per day:_____

If you have smoked but no longer smoke, when

did you stop:_____

NOISE EXPOSURE: YES NO

Type:_____Duration:_____

Remarks:_____

HEARING AID: YES NO

Ear Fitted: Right Left Both

Type:_____Where fit:_____

Remarks:_____