TREASURE VALLEY
Hearing & Balance
Hear Well. Live Well.

Patient Name _____

DOB: _____

# Medical History

**Thank you for helping us understand your unique situation by filling out the following.**

What is your goal for today's appointment? _____

How long have you noticed a decline in your hearing? ☐RECENTLY ☐1-3 YEARS ☐4-6 YEARS ☐7+ YEARS

When was your last hearing evaluation? _____Recommendation: _____

Do you currently use hearing aids? ☐NO ☐YES

Have you ever seen a physician specializing in diseases of the ear? ☐NO ☐YES when _____

List any **allergies** to medications, plastics, other? _____

Have you ever had ear surgery? ☐NO ☐YES please describe _____

List all major surgeries and illnesses within the last 10 years: _____

_____

Do you notice one ear being worse than the other? ☐NO ☐YES which ear? _____

Have you ever worked around noise? ☐NO ☐YES please describe _____

Please check all that apply:

☐I have an Android Smart Phone ☐I have an iPhone ☐I have a landline ☐ I have internet

Which ear do you use on the telephone? ☐RIGHT ☐LEFT

(Check all that apply) ☐Acute or chronic dizziness within the past 90 days

☐Diabetes ☐Vision Difficulties ☐Changes in your memory ☐Pain or discomfort in either ear

☐Thyroid ☐Blood thinner use ☐High blood pressure ☐Shoulder/Hip/Knee Replacement

☐Sudden or progressive hearing loss within the past 90 days ☐History of falling

☐Draining of blood or fluid from either ear in the past 90 days ☐Have you had chemotherapy or radiation?

☐Ringing in your ears ☐RIGHT ☐LEFT ☐ NEITHER Describe _____

☐Family history of hearing loss? ☐NO ☐YES WHO? _____

☐Family history of cognitive decline or Dementia? ☐NO ☐YES WHO? _____

Please list current medications here or bring a list with you: _____

_____

Primary Care Physician name: _____ City: _____

Would you like your test results sent to your primary care physician? ☐NO ☐YES