Dover Audiology
Let the conversation begin

PATIENT NAME: _____

DATE: _____

HEALTH HISTORY

1.	Do you have a history of ear infections?	☐ Yes	☐ No	
2.	Do you have pain in the ears?	☐ Yes	☐ No	
	If yes, please circle:	Left	Right	Both
3.	Do you have ringing in the ears?	☐ Yes	☐ No	
	If yes, please circle:	Left	Right	Both
4.	Do you have problems with dizziness or balance?	☐ Yes	☐ No	
5.	Do/es your ear/s feel full?	☐ Yes	☐ No	
	If yes, please circle:	Left	Right	Both
6.	Are you diabetic?	☐ Yes	☐ No	
7.	Do you take medications?	☐ Yes	☐ No	
8.	Do you have a family history of hearing loss?	☐ Yes	☐ No	
9.	Do you have trouble hearing with background noise?	☐ Yes	☐ No	
10.	Do you have problems hearing on the telephone?	☐ Yes	☐ No	
11.	Do you have a history of being around loud noise?	☐ Yes	☐ No	
12.	What is your/others major complaint about your hearing?	☐ Yes	☐ No	
13.	When was the last time you had your hearing tested?	☐ Yes	☐ No	
14.	Have you ever had a hearing aid?	☐ Yes	☐ No	
15.	What would you do to make it better if you could? _____			
16.	Did a doctor send you here?	☐ Yes	☐ No	

Please see and complete the next page for your privacy rights. Thank you.

Signature: _____

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