Mark H. Scoones, Au.D., FAAA
Doctor of Audiology

Patient History

Name ______________________________ Date ______ /______ /______
First Last MI MM DD YYYY

Primary Care Physician ______________________ Referring Physican ______________________

Have we seen you in this office before? ☐ YES ☐ NO

Describe the problem/reason for this evaluation ______________________________

____

Do you feel you have hearing loss? ☐ YES ☐ NO

If YES, please answer the questions below:

When did you first notice your hearing problem? ______________________________

____

Has the onset and progression of your hearing problem been ☐ SUDDEN ☐ GRADUAL

Severity of loss? ______________________________

____

Do you hear better in one ear than the other? ☐ YES ☐ NO

If YES, in which ear do you hear better? ☐ RIGHT ☐ LEFT

Does your hearing seem to fluctuate? ☐ YES ☐ NO

Do you experience fullness in your ears? ☐ YES ☐ NO

Check all that apply to your hearing difficulties

☐ Can hear but have problems understanding ☐ Children's voices ☐ Group of people or multiple talkers

☐ In the presence of background noise ☐ Large group conversations ☐ One-to-one conversations

☐ Small group conversations ☐ Telephone conversations ☐ TV volume is loud to others ☐ Women's voices

☐ Other ______________________________

Do you experience tinnitus (ringing or buzzing) in your ears or other head noises? ☐ YES ☐ NO

If YES, please answer the questions below:

In which ear(s) do you experience tinnitus? ☐ RIGHT ☐ LEFT ☐ BOTH

How long have you experienced tinnitus? ______________________________

Is it high- or low-pitched? ______________________________

Is it a single noise or multiple sounds? ______________________________

Is it a pulsation or is there a rhythmic quality present? ______________________________

Is it constant or intermittent? ______________________________

If intermittent, how often does it happen and how long does it last? ____________________

____

Do you notice tinnitus in quiet situations? ☐ YES ☐ NO

Do you notice tinnitus in noisy situations? ☐ YES ☐ NO

Have you experienced dizziness within the last six months? ☐ YES ☐ NO

If YES, do you experience ☐ Balance Difficulty ☐ Lightheadedness ☐ Spinning Sensation

Other ____________________

Have you had any significant noise exposure either work- or hobby-related? ☐ YES ☐ NO

If YES, please answer the questions below:

Number of years exposed to noise ____________

Job title/description ____________________

Employer at time of noise exposure ____________________

☐ Currently employed ☐ Unemployed at this time

Date of retirement or termination ____________

Recreational activity or hobby of significant noise exposure ____________________

____

Do you utilize hearing protection devices? ☐ YES ☐ NO

How often do you use hearing protection? ____________________

Have you had any ear infections or drainage? ☐ YES ☐ NO

If YES, please answer the questions below:

Did you have ear infections as a ☐ CHILD ☐ ADULT ☐ BOTH

Date of last infection ____________________

History of medical conditions related to your hearing; check all that apply

☐ Ear Pain ☐ Laceration of the Ear ☐ Perforation of the Eardrum

☐ PE Tubes ☐ Soreness in the Canal ☐ Trauma to the Ear

☐ Ear Surgeries (please list procedure and date of procedure) ____________________

____

History of medical conditions; check all that apply

☐ Acoustical Trauma ☐ Allergies ☐ Arthritis ☐ Blurred Vision ☐ Cancer ☐ Cholesterol ☐ Diabetes Mellitus

☐ Illness with High Fever ☐ Headaches ☐ Heart/Cardiac Problems ☐ High Blood Pressure

☐ Severe Blow to the Head ☐ Sinus Problems ☐ Stroke

Do you have any family members who had hearing loss before age 50? ☐ YES ☐ NO

If YES, please list their relationship to you ____________________

When was the last time you had your hearing tested and where? ____________________

Have you ever wore or tried hearing instruments? ☐ YES ☐ NO

If YES, please answer the questions below:

How long ago? ____________________

Where did you purchase the hearing instruments? ____________________

List all current medications on the attached form.

WEST COAST
HEARING CLINIC
We listen to your hearing needs

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Medication Documentation

Due to the new insurance guidelines for audiologist, it is mandatory that we document current medications prior to billing for your services.

Please complete this form and bring it with you to your appointment.

(Completion of this form is not necessary if you have a pre-printed list of your medications. Please give the list to the receptionist to copy.)

Please list each medication you are currently taking, including prescriptions, over-the-counter, herbals, vitamins/mineral/dietary supplements.

Medication Name	Dosage	Frequency	Route (oral, shots, dermal, etc.)

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