ACADIAN HEARING SERVICES

Name: _____ Today's Date _____/_____/_____

What is the primary reason for your visit today? _____

MEDICAL HISTORY

Do you have now or ever had any of the following: (please circle all that apply)

Diabetes	Arthritis	Hepatitis	Irregular heartbeat	Drug addiction
High blood pressure	Cancer ___Radiation	Seizure disorder	Heart attack	Parkinson's Disease
Stroke	___Chemotherapy	Asthma	HIV/AIDS	Dementia
Kidney disease	Chronic lung disease	Eye disease ___Glaucoma	Alcoholism	Alzheimer's Disease
Thyroid problem	Tuberculosis	___Macular degeneration	Psychiatric treatment	

Any other problems not listed_____

List and date any operations you have had _____

List all medications (including vitamins and over-the-counter medicines) below and what they are for:

please list additional medications on the back if needed

MEDICATION	MEDICAL CONDITION	DOSAGE	ROUTE (ORAL, TOPICAL, ETC)

How do you feel your hearing is?_____

Describe where you are noticing hearing difficulties _____

Have you ever had a hearing test before? Yes No

Briefly explain the results: _____

Do you currently, or have you ever worn a hearing aid? Yes No

If yes, please list what style, brand, year purchased and which ear _____

If recommended, are you interested in improving your hearing with a hearing aid? Yes No

Does hearing loss run in your family? Yes No If yes, Whom? _____

Do you have a history of noise exposure or noisy hobbies? Yes No

If yes, describe: (Ex: hunting, at work, carpentry, etc.) _____

Have you used tobacco in any form within the last 2 years? Yes No

Have you fallen 2 or more times within the last 12 months? Yes No Any fall-related injury?_____

Do you have tinnitus (ringing, hissing, buzzing, etc.)? Yes No If yes, which ear?_____

When did it first begin?_____ How long does it last?_____

Do you have any dizziness, vertigo, loss of balance, or lightheadedness? Yes No

If yes, when did it first begin_____ How long does it last?_____

How often does it occur?_____