VIRSONO
Hearing Center

Medical and Hearing Health History

Your ear is part of your entire body and health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Thank you for completing all fields

Medical History

Do you have a history of diabetes? ☐No ☐Yes

Do you have a history of cardiovascular disease? ☐No ☐Yes

Have you fallen recently? ☐No ☐Yes

Are you currently taking Anticoagulants? ☐No ☐Yes for how many years? _____

History of dermatitis or other skin conditions ☐No ☐Yes Please describe _____

Do you currently use tobacco? ☐No ☐Yes If yes, how often _____

Have you experienced head trauma? ☐No ☐Yes If yes, please explain _____

_____

Do you have allergies to medications, plastics, etc? ☐No ☐Yes _____

_____

Do you have any concerns about your short-term or long-term memory? ☐No ☐Yes

If yes, please describe _____

Any history of significant illnesses, surgeries, injuries or hospitalizations ☐No ☐Yes

Please describe _____

Current list of medications with dosages _____

_____

Any additional information you would like us to know about? _____

_____

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Hearing Health History

Have you experienced acute or chronic dizziness in the last 90 days? ☐No ☐ Yes

Have you experienced pain in your ears in the last 90 days? ☐No ☐ Yes Describe _____

_____

Have you experienced any draining or discharge from your ears in the last 90 days? ☐No ☐ Yes

If yes, which ear? ☐Left ☐ Right ☐Both

Have you experienced a sudden hearing loss in one or both ears in the last 90 days? ☐No ☐ Yes

If yes, which ear? ☐Left ☐ Right ☐Both

How long have you noticed difficulties with your hearing? _____

In which ear is the hearing the worst? ☐Left ☐ Right ☐Same

Was your change in hearing sudden or gradual? _____

Do you have a history of noise exposure? ☐No ☐ Yes Describe _____

What do you think caused your hearing loss? _____

Do you have a family history of hearing loss? ☐No ☐ Yes _____

Date of most recent hearing test _____

Do you currently use hearing devices? ☐Left ☐ Right ☐Both For How Long? _____

What do you like or not like about your current devices?_____

Do you experience Tinnitus? (ringing, buzzing, hissing, etc.) ☐Left ☐ Right ☐Both

Do you have a feeling of fullness in your ears? ☐Left ☐ Right ☐Both

Have you been told you have small or narrow ear canals? ☐No ☐ Yes

Which ear do you use to talk on the phone _____

Is there anything else you would like us to know? _____

_____