North Florida Hearing & Balance Center

PRE-EVALUATION CASE HISTORY FORM FOR HEARING EVALUATION

Date: _____

Patient Name: _____
(Last) (First) (Middle)

Mailing Address: _____
(Street) (Apartment/Unit #)

_____
(City) (State) (Zip)

Home Phone: _____ Alternate Phone: _____

E-Mail Address: _____

Date of Birth: _____ Male: _____ Female: _____

Marital Status: _____ Number of Children: _____

Number of People in Household: _____ Ages of People in Household: _____

Emergency Contact: _____ _____
(Name/Relationship) (Phone)

Primary Care Physician's Name: _____

Primary Care Physician's Address: _____

_____

I authorize North Florida Hearing & Balance Center to send a copy of my hearing evaluation test results to my Primary Care Physician:

Patient's Signature and Date: _____

How Did You Hear About Us? *(Please circle one)*

Referred by Doctor Referred by Friend/Family (Name): _____

Yellow Pages Internet Mail Ad Newspaper Ad Saw Sign

Other: _____

Medical History:

Please check any of the following medical conditions that pertain to you now or in the past:

Stroke __	Ears Ringing __	Dizziness __	Cancer __
Surgery __	Visual Problems __	Headaches __	Mumps __
Measles __	High Blood Pressure __	Paralysis __	Seizures __
Diabetes __	Ear Infections __	Head Trauma __	Meningitis __
Earaches __	Kidney Problems __	Heart Attack __	Ear Drainage __
Excessive Stress __	Fibromyalgia __	TMJ __	Meniere's Disease __
Sinus Problems __			

Describe Frequency of Any of the Checked Conditions: _____

_____

Describe Any Medical Treatment/Condition or Hospitalization and date: _____

_____

Are You Currently Under Medical Treatment? Yes _____ No _____

If "Yes," Please Describe: _____

Are You Taking Any Prescribed or Over-the-Counter Medications? Yes _____ No _____

If "Yes," Please List: _____

_____

Describe Your Current Physical Condition:

Excellent _____ Good _____ Fair _____ Poor _____

Hearing History:

What Prompted You to Schedule this Evaluation? _____

Is There a History of Hearing Loss in Your Family? Yes _____ No _____

If "Yes," Please List: _____

Please Describe Any Hearing Difficulties You Have at Home, at Work and/or in Social Situations:

_____

_____

Hearing History (continued):

When Were Your Hearing Difficulties First Noticed? _____

Who First Noticed Your Hearing Difficulties? _____

Are Your Hearing Difficulties Always Present? Yes _____ No _____

In Your Opinion, What is the Cause of Your Hearing Difficulties? _____

_____

_____

Have You Ever Consulted Anyone About Your Hearing? Yes _____ No _____

If "Yes," Whom? _____

Were Recommendations Given? Yes _____ No _____

If "Yes," What Were They and Were They Effective? _____

_____

Have You Ever Worn a Hearing Aid? Yes _____ No _____

If "Yes," For How Long? _____

Are You Currently Wearing a Hearing Aid? Yes _____ No _____

If "Yes," Which Ear? Both _____ Left _____ Right _____

Type of Hearing Aid: Behind the Ear _____ In the Ear _____ In the Canal _____

Age of Current Hearing Aids: _____

Where Did You Purchase These Hearing Aids? _____

Are You Satisfied With Their Performance? Yes _____ No _____

If "No," Please Explain: _____

_____

Noise Exposure:

Have You Ever Served in the Armed Forces? Yes _____ No _____

If "Yes," Which Branch? _____

For How Long? _____

Duties (Include Noise Exposure): _____

List Any Occupations That Involved Steady Exposure to Noise: _____

_____

List Any Activities That Subjected You to Loud Noises (i.e., Hunting, Using Power Tools, etc.):

_____

_____

Are You Bothered by Loud Noises? Yes _____ No _____

If "Yes," Please Describe: _____

_____

Please Tell Us Anything Else That You Feel May Be Useful in Our Evaluation of Your Hearing:

_____

_____

_____

Clinical Notes: _____

_____

_____

_____

_____

_____

_____

_____