**Life Hearing Solutions, PLLC**
110B Town Commons Drive, Shelby, NC 28152

**PATIENT HISTORY**

Name_______________________________________ Date of Birth ________________Age _______

Referring Doctor or Primary Care Physician_______________________________________________

Would you like us to send a report to your doctor? ________Yes ________ No

What is the reason for today's visit? ______________________________________________________

**AUDIOLOGIC HISTORY:**

Are you, or have you, experienced any of the following conditions?

History of chronic ear infections as a child or adult?________________________________________

History of ear surgery?_______________ If so, right or left ear, and when?____________________

History of trauma to the head? __________________________________________________________

Ringing in your ears? (ringing, buzzing, hissing) _____________________________________________

If yes, which ear? ____________ How frequent? ______________ Since when? __________

Dizziness, vertigo, or loss of balance? ___________________________________________________

If yes, please describe when it began, the duration, and how often it occurs _______________

____________________________________________________________________________

Otalgia (or ear pain)?__________________________________________________________________

Fullness in your ears?_________________________________________________________________

Sinus or allergy problems? ____________________________________________________________

Have you experienced any extreme sensitivity to sound?_________Distortion of sound?__________

Family history of hearing loss? _________________________________________________________

History of noise exposure? ____________________________________________________________

Have you ever had your hearing tested before? ____________________________________________

If so, when was the last time you were tested? _______________________________________

Have you ever worn a hearing aid? ______________________________________________________

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**MEDICAL HISTORY:**

How is your general health? ____________________________________________

Have you used tobacco within the last 2 yrs?____________________________________

Recent hospitalizations/surgeries? _______________________________________

_____________________________________________________________________

Have you had or currently have any of the following:

_____Arthritis _____Cancer _____Pre-diabetes/Diabetes

_____Head Trauma _____Heart/Vascular Disease _____High Blood Pressure

_____Pacemaker _____ Blood Disorder _____Kidney Disease

_____Meningitis _____Stroke _____Vascular Problems

_____Visual Problems _____HIV/Syphilis _____Depression

Please list any chronic conditions, other than those listed above, for which you have been, or are currently being treated? _____________________________________________

_____________________________________________________________________

Please list any medications that you are currently taking:

| Medication | Dosage | How Often | Taken For | Prescribing Doctor |
|---|---|---|---|---|
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Patient's Signature ________________________________ Date: ________________