



Complete the following information prior to your appointment.

Please email to info@modernaudiologysparks.com or bring to your scheduled appointment.

CASE HISTORY

Patient Name: _____

1. What is your primary concern? _____
2. What do you think caused your hearing problem? _____
3. If you have a hearing loss, how long have you noticed it? _____
4. Which is your worse ear? Left:_____Right:_____ No Difference: _____
5. How important is it for you to improve your hearing, understanding, or communicative ability?



Hearing History

- | | |
|--|------------------|
| 1. Have you had your hearing tested before? | Yes_____No _____ |
| 2. Any drainage from the ear(s) within the past 90 days? | Yes_____No _____ |
| 3. Have you experienced any dizziness, balance problems, or falls? | Yes_____No _____ |
| 4. Have you had any pain/discomfort in your ear(s)? | Yes_____No _____ |
| 5. Do you have any noises (ringing, buzzing, etc.) in your ears? | Yes_____No _____ |
| 6. Have you received any medical or surgical treatment for hearing loss? | Yes_____No _____ |
| 7. Have you ever been exposed to loud noise? | Yes_____No _____ |
| 8. Is there a history of hearing loss in your immediate family? | Yes_____No _____ |

If yes, who: _____

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9. Medical problems (check all that apply):

Infectious disease _____ High blood pressure _____ Diabetes _____
Head injury _____ Use of pain medications _____ Heart Problems _____
Kidney failure _____ Pacemaker/Defibrillator _____ Headache _____

Other (please explain): _____

10. Have you ever worn a hearing aid(s)? Yes _____ No _____

11. How confident are you in your own ability to use and take care of hearing aids (if recommended)?



12. Select all that apply:

- _____ I have been thinking I might need hearing aids.
- _____ I am comfortable with the idea of wearing hearing aids.
- _____ I have started to seek information about hearing aids
- _____ I am ready to wear hearing aids if they are recommended.

Other comments or questions: