SILVER STATE
HEARING & BALANCE

Patient Case History

Medical History

Yes No Have you seen a doctor in the past six months? (Dr. ____________________)
Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, when and who? ____________________
Yes No Have you ever had any type of ear surgery?
If yes, what type and when ____________________
Yes No Do you have any medical conditions?
If yes, list ____________________
Yes No Are you currently taking any medications?
If yes, describe ____________________
Yes No Are you hypertensive?
Yes No Are you nervous?

Ear and Hearing History

Yes No Do you have any deformity of the ear?
Yes No Do you have any pain in your ears?
Yes No Do you have any drainage from your ears?
Yes No Have you ever seen a doctor for wax removal?
Yes No Do you have any dizziness and/or concerns regarding your balance?
If yes, describe ____________________
Yes No Have you ever had your hearing tested?
If yes, when? ____________ By whom? ____________
Was hearing loss found? Yes No Unknown
Yes No Have you had any sudden or rapid loss of hearing in the past 90 days?
If yes, describe ____________________
Yes No Do you have a history of noise exposure (work or recreational related)?
If yes, describe ____________________
Yes No Do you feel you hear better out of one ear vs. the other?
If yes, which is your *better* ear? Right Left
Yes No Do you have any ringing/noises in your ears?
If yes, describe ____________________
Yes No Does anyone in your family have hearing loss?
If yes, what relationship? ____________________
Do you experience difficulty hearing in any of the following situations?
Yes No Understanding conversation in quiet
Yes No Hearing in groups/meetings/social gatherings
Yes No Hearing/understanding on the telephone
Yes No Hearing/understanding the television
Yes No Do you now or have you ever worn a hearing aid?
What is your goal and/or desired outcome for your appointment today? ____________________

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Thank you for taking the time to provide us with this information.