Eagle Hearing

208-939-9359
Fax: 208-939-9453

www.eaglehearing.com avore@eaglehearing.com 440 E. State St. Suite 100 - Eagle, ID 83616

Confidential Adult Patient History

Patient Name: **Birth Date:** **Today's Date:**
Address:
City: **State:** **Zip Code:**

Please complete the following:

What is the primary reason for your visit today? Please explain your hearing health history in detail.

MEDICAL HISTORY:

Who is your primary physician? _____

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, give date _____
Yes No Have you ever had your hearing tested?
If yes, give date _____ by whom _____
Yes No Have you ever had any type of ear surgery?
If yes, type of surgery? Name of the physician that completed the surgery?

Yes No Do find yourself frequently breathing with your mouth instead of your nose?
Yes No Do you snore?
Yes No Do you experience sinus pressure or pain?
Yes No Do you experience acid reflex frequently?
Yes No Do you experience allergies?

Please list medications and what conditions they are for:

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Please list any medical conditions that have not been mentioned?

Yes No Do you have any vision issues?

ABOUT YOUR EARS: Do you have any of these symptoms?

Yes No Deformity of the ear
Yes No Drainage from the ear
Yes No Sudden or rapid loss of hearing in the past 90 days
Yes No Acute or chronic dizziness
Which is your poorer ear? Same Right Left
Yes No Have you ever seen a doctor for wax removal?
Yes No Do you ever have pain in your ears?
Yes No Do you have tinnitus (ringing of the ears)?
Yes No Do you have a history of significant noise exposure?

ABOUT YOUR HEARING: Do you experience difficulty with the following?

Yes No How long have you had a hearing problem? _____
Yes No Does anyone else in your family have a hearing problem?
What relationship? _____
Yes No Have you ever worn a hearing aid?

Who referred you to us? _____

Signature _____ Date _____