LAKESIDE AUDIOLOGY
(240) 318-5092

10401 Hospital Drive, Suite G4
Clinton, MD 20735

CASE HISTORY

PATIENT NAME: _____ **Age:** _____ **Date:** _____

1. Do you have any of the following symptoms?

- ▢ **Hearing Loss** ▢ Right ear ▢ Left ear
- ▢ **Difficulty hearing** ▢ In Quiet ▢ In Noise
- ▢ **Tinnitus/Ringing** ▢ Right ear ▢ Left ear
- ▢ **Changes in Hearing** ▢ Gradual ▢ Sudden
- ▢ **Ear fullness/pressure**
- ▢ **Ear pain**
- ▢ **Dizziness**
- ▢ **Other** _____

2. How long have you noticed these symptoms? _____

3. What is the cause of these symptoms, if known? _____

4. Have you ever been exposed to loud noise, either recently or in the past? ▢ Yes ▢ No
If yes, what type of noise? _____ For how long? _____

5. Have you seen an Ear, Nose and Throat (ENT) physician? ▢ Yes ▢ No
If yes, who did you see? _____ When? _____

6. Have you ever had surgery that may have affected your hearing? ▢ Yes ▢ No

7. Is there a history of hearing loss in your family? ▢ Yes ▢ No If yes, who? _____

8. Have you ever had an ear infection? ▢ Yes ▢ No If yes, ▢ as a child ▢ as an adult
▢ Right Ear ▢ Left Ear ▢ Both ears Date of most recent ear infection: _____

9. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?
▢ Yes ▢ No If yes, please describe: _____

10. Do you wear hearing aids? ▢ Yes ▢ No If yes, for how long? _____ What type? _____
Are you satisfied with your current amplification? ▢ Yes ▢ No ▢ Not sure

11. Are you seeking new hearing aids or hearing aids for the first time? ▢ Yes ▢ No ▢ Not sure

GENERAL MEDICAL HISTORY

12. Please check any of the following that you have or have had in the past:

▢ Arthritis	▢ Asthma	▢ Heart Problems	▢ Measles	▢ Parkinson's
▢ Hepatitis	▢ Meningitis	▢ Bell's Palsy	▢ Sinusitis	▢ High Blood Pressure
▢ Diabetes	▢ HIV	▢ Visual Trouble	▢ Stroke/TIA	▢ Head Injury

▢ Other: _____

MEDICATIONS

13. Please list all current medications, prescription or over-the-counter, that you take on a regular basis:
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
If needed, please continue medication list on the back of this page. You may also provide your own list.