Alaska Hearing & Tinnitus Center

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Doctor of Audiology
1005 E. Dimond Blvd Unit 3, Anchorage, AK 99515
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Name: (Last) (First) Age: Date:

Date of Birth: Address:

City:

State: Zip Code:

1. What is the primary reason for today's visit:

2. Are you experiencing problems with your hearing? **Yes / No**

Which ear? **Both / Right / Left**

3. Has the hearing loss been: **Gradual / Sudden / Fluctuating**

4. How long have you noticed problems with your hearing?

Recently / 1-3 / 4-6 / 7-10 / More than 10 Years

5. What do you think may have caused this?

6. Have you had your hearing tested before? **Yes / No**

If yes, when:

7. What was the outcome of your previous hearing test?

No loss / Mild loss / Hearing aids recommended

8. Do you currently use a hearing aid? **Yes / No**

9. Have you ever used a hearing aid(s)? **Yes / No**

10. Do any members of your family have a hearing problem? **Yes / No**

11. Do you have a history of ear infections? **Yes / No**

12. Have you had any of the following in the last six months?

(Circle all that apply) **Medically diagnosed ear pathology / Ear pain**
Pressure or fullness in the ears / Ear drainage

13. Have you had surgery on your ears? **Yes / No**

If Yes, Which ear? **Both / Right / Left**

14. Do you hear noises in your ears or head? (Tinnitus) **Yes / No**

Which ear? **Both / Right / Left**

If Yes, how often do you hear these noises?

Constantly / Frequently / Occasionally / Very Seldom

15. How would you describe the noise?

Ringing / Buzzing / Roaring / Screeching / Crickets / Pulsating

16. Are you experiencing any problems with dizziness? **Yes / No**

If Yes, is your dizziness accompanied by the following? (Circle all that apply)

Nausea / Vomiting / Noises in your ears / Loss of Consciousness

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17. Do you have or have you had any of the following? (Circle all that apply)

Sinuses/Allergy	**Meningitis**	**Mumps**
Measles	**Thyroid**	**Diabetes**
Stroke	**Heart Attack**	**High Blood Pressure**
Head Injury	**Arthritis**	**Appetite Change**
AIDS/HIV	**Cancer**	**Blood Disorder**
High Cholesterol	**Chicken Pox**	**Diphtheria**
Encephalitis	**Fatigue**	**Genetic Disorders**
Headaches	**Heart Problems**	**High Fevers**
Scarlet Fever	**Stroke**	**Tonsillitis**
Vascular Problems	**Typhoid**	

Other:

18. Do you take medications regularly? (Please list on sheet provided) **Yes / No**

19. Allergies to medication or plastics?

20. Have you ever been exposed to excessively loud noises? **Yes / No**

21. Are you currently employed? **Yes / No / Retired**

22. What is or was your occupation?

PLEASE CHECK ALL MEDICAL SYMPTOMS THAT APPLY:

23. Eye Problems? (such a s blurred vision or pain): **Yes / No**

24. Nose, throat or mouth problems? **Yes / No**
(such as trouble swallowing, nose bleeds, denture issues, pain)

25. Cardiovascular Symptoms? **Yes / No**
(such as hypertension, chest pain, swelling, palpitations, heart surgery)

26. Respiratory Symptoms? (such as shortness of breath, cough, wheezing) **Yes / No**

27. Gastrointestinal Issues? (nausea, vomiting, weight changes, diarrhea) **Yes / No**

28. Musculoskeletal Symptoms? (such as joint pain, swelling, recent trauma) **Yes / No**

29. Neurological Symptoms? **Yes / No**
(such as numbness, headaches, seizures, muscles weakness)

30. Psychiatric Issues? (such as depression, anxiety, compulsions) **Yes / No**

31. Endocrine Symptoms? (such as frequent urination, hot flashes) **Yes / No**

32. Hematologic / Lymphatic Symptoms? **Yes / No**
(such as bleeding gums, bruising, swollen glands, clotting issues)

33. Allergic / Immunologic Symptoms? **Yes / No**
(such as hives, asthma, itching, immune deficiency)

Doctor Notes: