5020 Ritter Road, Suite 106
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Duncan Nulph HEARING ASSOCIATES

www.dnhearing.com
717-766-1500

Patient History Form

Patient Name: ______________________________ **DOB:** ____________________

1. Chief complaint: ☐ Hearing Loss (☐ Right ear / ☐ Left ear / Both) ☐ Tinnitus / Ringing ☐ Dizziness
   ☐ Difficulty Hearing (☐ in Quiet / ☐ in Noise) ☐ Telephone (☐ Right ear / ☐ Left ear)

2. How long have you noticed this difficulty? ______________________________

3. Do you think your hearing is changing? ☐ Yes ☐ No (If yes, ☐ Gradual ☐ Sudden)

4. Have you ever been exposed to loud noise, either recently or in the past? ☐ Yes ☐ No
   If so, please mark all that apply:
   ☐ Farm Machinery ☐ Music ☐ Hunting/Shooting ☐ Factory Noise
   ☐ Power Tools ☐ Military ☐ Jet Engines ☐ Other ____________________

5. Do you have any of the following symptoms? ☐ Deformity of the ear ☐ Drainage of the ear ☐ Tinnitus (ringing)
   ☐ Sudden or rapid hearing loss within the past 90 days ☐ Acute or chronic dizziness/imbalance ☐ Ear pain

6. Have you ever had your hearing tested? ☐ Yes ☐ No
   Is so, when was your last test? ______________ By whom? ______________________________

7. Have you seen an Ear, Nose and Throat physician? ☐ Yes ☐ No
   If so, who did you see? ______________________________ When? ________________

8. Have you ever had surgery that may have affected your hearing? ☐ Yes ☐ No Type? ____________________

9. Which ear do you hear better out of? ☐ Same ☐ Right ☐ Left

10. Is there a history of hearing loss in your family? ☐ Yes ☐ No If so, who? ____________________

11. Have you ever had an ear infection? ☐ Yes ☐ No (If yes, ☐ as a child ☐ as an adult)

12. Do you take any prescription medications on a regular basis? Please list: (or provide a list)
    Medication: ______________________________ For: ______________________________
    Medication: ______________________________ For: ______________________________
    Medication: ______________________________ For: ______________________________

13. Please check any of the following that you currently have or have had in the past:
    ☐ Arthritis ☐ Head Injury ☐ HIV ☐ Mumps ☐ Sinusitis
    ☐ Asthma ☐ Heart Trouble ☐ Malaria ☐ Neurological Symptoms ☐ Stroke / TIA
    ☐ Bell's Palsy ☐ Hepatitis ☐ Measles ☐ Parkinson's ☐ Visual Trouble-Loss/Sight
    ☐ Diabetes ☐ High Blood Pressure ☐ Meningitis ☐ Scarlet Fever

14. If a hearing aid is recommended for you, please rank the following in order of importance (1-4):
    ______ Improved hearing quiet ______ Improved hearing in noise ______ Cosmetic appearance ______ Expense

15. If you are currently using a hearing aid, or have in the past, please answer the following:
    Which ear is/was aided? ☐ Right ☐ Left ☐ Both
    How long have you used a hearing aid? ______________

Patient or Representative Signature ______________________________ **Date** ________________

Name of Representative & Relationship to Patient (parent, guardian, POA, etc) ______________________________