acoustic hearing center

Acoustic Hearing Center
1163 Willis Avenue, Albertson, NY
11507-1203
(516) 484-0811

ADULT HEARING HEALTH PROFILE

PATIENT NAME: ______________________ **APPOINTMENT DATE:** ___________

What is the purpose of your visit? ____
Indicate any current medical conditions for which you are being treated:
____

1. Have you noticed a hearing loss? ☐ **No** ☐ **Yes,** which ear? ☐ **Left** ☐ **Right** ☐ **Both**

If yes, ☐ **5 or more years** ☐ **More than 1 year** ☐ **Less than 1 year** ☐ **Less than 90 days**

2. Have you had any pain or discomfort in your ears? ☐ **No** ☐ **Yes,** which ear? ☐ **Left** ☐ **Right** ☐ **Both** If yes, ☐ **5 or more years** ☐ **More than 1 year** ☐ **Less than 1 year** ☐ **Less than 90 days**

3. Have you noticed any drainage from your ears? ☐ **No** ☐ **Yes,** which ear? ☐ **Left** ☐ **Right** ☐ **Both** If yes, ☐ **5 or more years** ☐ **More than 1 year** ☐ **Less than 1 year** ☐ **Less than 90 days**

4. Do you have any noises or ringing in your ears? ☐ **No** ☐ **Yes,** which ear? ☐ **Left** ☐ **Right** ☐ **Both** If yes, ☐ **Intermittent** ☐ **Constant** ☐ **Pulsatile**

5. Have you experienced any balance problems, dizziness, or falls? ☐ **No** ☐ **Yes** If yes,

☐ **Dizziness** ☐ **Unsteadiness** ☐ **Vertigo**

6. Have you discussed the above conditions with your MD? ☐ **No** ☐ **Yes, describe:**
____

7. Have you received any medical / surgical treatment for hearing or ears? ☐ **No** ☐ **Yes, describe:** ____

If yes, ☐ **5 or more years** ☐ **More than 1 year** ☐ **Less than 1 year** ☐ **Less than 90 days**

8. Have you had your hearing tested before? ☐ **No** ☐ **Yes,**when & where: ______________________
What were the results? ____________________

9. Have hearing aids been recommended and/or are you using them now? ☐ **No** ☐ **Yes**
If yes, how long: _____________

10. Describe your experience with your current hearing aids:

☐ **Unsatisfied** ☐ **Satisfied** ☐ **Undecided**

11. Have you been exposed to loud noise? ☐ **No** ☐ **Yes**

12. Is there a history of hearing loss in your immediate family? ☐ **No** ☐ **Yes**

Patient Signature: __________________________________