Patient Medical
Health Inventory

Hearing ~ Balance ~ Health
…live your best life…

NARO
AUDIOLOGY & HEARING SOLUTIONS

Patient Name :: _____ **DOB:** _____
[First] [MI] [Last] [MM / DD / YYYY]

Primary reason(s) for today's visit? _____

_____

Hearing Loss Symptoms:

☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ Constant ☐ Fluctuating :: Describe: _____

☐ Gradual ☐ Sudden :: Date of onset: _____

Communication Problems:

☐ Quiet	☐ Noise	☐ Face-to-face	☐ In groups
☐ In the car	☐ Auditoriums	☐ Close proximity	☐ Direction of sound
☐ On phone	☐ Church	☐ At a distance	☐ Television
☐ Listening to music	☐ Theater	☐ Outside	☐ Radio

Other :: _____

Related Complaints:

Tinnitus / Ringing ::	☐ Right Ear	☐ Left Ear	☐ Both Ears
☐ Dizziness	☐ Balance /Unsteady	☐ History of falls	☐ Nausea
☐ Ear pain	☐ Ear drainage	☐ Ear fullness	☐ Headaches
☐ Noise exposure	☐ Speech problems	☐ Language problems	☐ Vision Problems
☐ Family history of hearing loss		☐ Facial numbness / tingling	

Other :: _____

Medications:

Check following medications you have taken in the past 2 years, or are currently taking:

☐ Streptomycin	☐ Neomycin	☐ Kanamycin	☐ Quinine
☐ Chemotherapy	☐ Aspirin	☐ Anti-inflammatory	☐ Diuretics

List current medications (provide separate list if needed) :: _____

_____

_____

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General Health (Past & Current):

☐ Ear infections	☐ High blood pressure	☐ Meningitis	☐ Memory deficits
☐ Ear surgery	☐ Stroke	☐ Thyroid disorder	☐ Dementia
☐ Ear tubes	☐ Heart attack	☐ Kidney disease	☐ Alzheimer's
☐ Sinusitis	☐ Heart surgery	☐ Pneumonia	☐ Parkinson's
☐ Asthma	☐ Circulatory problems	☐ Viral infections	☐ Bells' Palsy
☐ Allergies	☐ High cholesterol	☐ Cancer	☐ Cerebral Palsy
☐ Bronchitis	☐ Low blood sugar	☐ HIV	☐ Neurological Issues
☐ Diabetes	☐ Hepatitis	☐ Malaria	☐ Seizures
☐ Anemia	☐ Scarlet /High fever	☐ Measles	☐ Traumatic Brain Injury
☐ Arthritis	☐ Upper Respiratory	☐ Mumps	☐ Neck injury

Have you seen an Ear, Nose and Throat physician? ☐ Yes ☐ No

If yes, physician name :: _____ Approx. when :: _____

Have you ever had surgery that has affected your hearing? ☐ Yes ☐ No

Have you ever seen a doctor for wax removal? ☐ Yes ☐ No

Have you ever had an ear infection? ☐ Yes ☐ No ☐ Child ☐ Adult

Assistive Device Use:

- Do you use a ☐ cane ☐ wheelchair ☐ walker?
- Do you currently use an assistive listening device? ☐ Yes ☐ No
- If so, please describe :: _____

Hearing Aid Use:

☐ No experience ☐ Currently wearing devices :: Approximate length of use: _____

☐ Trial use only ☐ Satisfied with devices

☐ Past experience ☐ Devices not adequate :: _____

If a hearing aid evaluation is indicated in today's visit, please select all items of importance. Please rank items of importance from greatest to least with 1 being the most important.

	Rank		Rank		Rank
☐ Visibility		☐ Rechargeable		☐ Maintenance	
☐ Expense		☐ Bluetooth Connectivity		☐ Use w/ Cell Phone	
☐ Ease of Use		☐ Sound Quality		☐ Reliability / Quality	

To the best of my knowledge, the above information is accurate.

Patient Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____