ATLAS AUDIOLOGY

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Hearing Health Profile

Patient Name:_____ Age: _____ DOB: _____

Approximate date of last hearing test: _____

2. Chief complaint: Hearing Loss?: ___ Right ear ___ Left ear ___ Tinnitus/Ringing?
___ Dizziness? ___ Difficulty hearing?: ___ In Quiet ___ In Noise ___ Telephone

3. How long have you noticed this difficulty?
_____

4. Primary reason for visit: _____

5. Have you ever worn a hearing aid? (Circle) Yes or No

6. Do you wear hearing aids now? (Circle) Yes or No
If so, what brand/style?_____ Right ear / Left ear / Both ears

7. Is this problem due to a work-related injury/exposure? ___ Yes ___ No
If so: Date of Injury: _____
Explain:_____
__

8. Do you feel your hearing is changing? ___ Yes ___ No (___ Gradual ___ Sudden)

9. 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
___ Military ___ Factory Noise ___ Power Tools ___ Jet Engines ___ Other:
_____

10. Have you ever had any ear surgery? ___ Yes ___ No

11. Is there a history of hearing loss in your family? ___ Yes ___No
If so, who? _____ Is this age related? ___ Yes ___No

12. Do you have a history of chronic ear infections? ___ Yes ___ No (If yes, ___as a child
___ as an adult)

13. Have you, in the past 10 years, experienced chronic or acute dizziness, light-headedness, or vertigo? ___Yes ___ No If yes, please describe:

_____

14. Do you take any prescription medications on a regular basis? Please list:

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Vitamins:

_____

15. Please check any of the following that you currently have or have had in the past:
___ Arthritis ___ Heart Trouble ___ Measles ___ Parkinson's ___ Asthma ___ Hepatitis ___Meningitis ___ Bell's Palsy ___ High Blood Pressure ___ Sinusitis ___ Diabetes ___ HIV ___ Neurological Symptoms ___ Stroke/TIA ___ Head Injury ___ Visual Trouble – Loss/Sight

16. If we find through our evaluation that we can help you, are you ready for that help?

_____

Consent To Test

I hereby consent to the analysis, diagnosis or treatment including, but not limited to, hearing tests, otoscopy, ear impressions, hearing aid fitting, of me by Atlas Audiology may be conditioned upon my consent as evidenced by my signature below. This consent includes consent to take a medical history and perform diagnostic and/or audiologic testing. I understand that

_____ _____

Patient/Guarantor/Parent Signature Date

For: _____