Personal Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Mx. ☐ Dr.

Last Name _____ Referred By _____

First Name _____ Family Doctor & Clinic _____

Reason for today's visit _____

Communication Concerns

Do you have any of the following communication concerns? (please select all that apply):

- ☐ Difficulty hearing people in quiet environments
- ☐ Difficulty hearing in background noise
- ☐ Difficulty hearing the TV
- ☐ Difficulty hearing on the phone
- ☐ Difficulty hearing people with accents

Additional information you think is relevant:

_____

_____

Hearing, Balance & Health History

Section 1: The following questions refer to ear blockage, fullness, pain sensitivity, ear sound and/or hearing difficulties experienced.

Have you ever had ear surgery? ☐ Yes ☐ No

- If Yes: **What for?** _____
  _____

Do you currently experience (or have in the past) ear blockage, fullness, pain, sensitivity to sound, ear sound (tinnitus) and/or hearing difficulty? ☐ Yes ☐ No ☐ Unsure

- If No: **Please skip this section and go to Section 2**
- If Yes: **In which ear?** ☐ Right ear ☐ Left ear ☐ Both

  For how long?_____

Do you have ear and/or head noise (tinnitus)? ☐ Yes ☐ No ☐ Unsure

- If Yes: **In which ear?** ☐ Right ear ☐ Left ear ☐ Both
  For how long?_____
  How bothersome is the noise? _____
  Please describe the noise _____

Do you have ear blockage, fullness, pain or sensitivity to sound? ☐ Yes ☐ No

- If Yes: **In which ear?** ☐ Right ear ☐ Left ear ☐ Both
  For how long?_____

Do you have hearing loss in your family? ☐ Yes ☐ No

- If Yes: **Which family member?**_____

Did you experience any of the following shortly before the first time you had ear blockage, fullness, pain, sensitivity to sound, ear sound and/or hearing difficulties:

- Forcefully coughed/sneezed, flying, diving
- Flu, cold, allergies, COVID
- Exposed to irritating fumes, paints, and/or loud music or noise
- Dental surgery/work, TMJ disorders and bruxism (i. e., grinding teeth)
- Head trauma and injury (i. e., sport or motor vehicle accidents)
- Chiropractic adjustments due to stiff neck
- Intense period of stress at work or in personal life

Are/were you regularly exposed to loud noise or music? Yes No

- If Yes: **Is it?** Work related Recreational
- If Work Related: **For how many years?** _____
  Do/did you wear ear protection? _____
- If Recreational: **What is/was it from?** _____

Are/were you regularly exposed to heavy metals and/or organic solvents? ☐ Yes ☐ No

- If Yes: **Is it?** Work related Recreational
- If Work Related: **For how many years?** _____
  Do/did you wear ear protection? _____
- If Recreational: **What is/was it from?** _____

Section 2: The following questions refer to sensation(s)/symptom(s) of imbalance, disequilibrium, dizziness or vertigo experienced.

Have you experienced imbalance, disequilibrium, dizziness or vertigo? ☐ Yes ☐ No

- If No: **Please skip this section and go to Section 3**
- If Yes: **Please select one that best describes the sensation or symptom experienced:**
  - Sensation that the room or surroundings are spinning around you when your body is at rest (lying or sitting position)
  - Vague feeling of being off-balance, unsteady, head discomfort
  - Feeling woozy, giddy, light-headed and/or that you are going to faint or black-out
  - Feeling of imbalance and disequilibrium when standing and walking without dizziness
  - Difficulty walking straight, staggering gait (like you are drunk), involuntarily bumping into things

Please select one that best describes the duration of the sensation/symptom described above:

- Less than one minute
- More than one minute
- Hour(s)
- Day(s)

When did you first experience this sensation/symptom? _____
How many episodes of the sensation described above have you had so far? _____

Please select the one situation that seems to trigger or bring about the sensation described above:

☐ Change in head position (while rolling or getting out of bed, quickly looking up or bending forward)
☐ During head extension while standing on a wobbling ladder or looking up
☐ When eyes are closed or while walking in the dark
☐ While standing up, especially after a long period of sitting
☐ When overworked or during intense periods of stress, anxiety, or distress
☐ With some medications, foods, drinks and recreational drugs

Please select <u>all other symptoms</u> that accompany the sensation described above:

☐ Ear and/or head noise (hissing, buzzing, blowing)
☐ Hearing difficulty, distorted hearing (things sound tinny)
☐ Ear blockage, fullness, earache
☐ Nausea, feeling hungover or seasick, vomiting, fatigued
☐ Visual problems (blurred vision, double vision, eyes jerking)
☐ Distress, sweating, trembling, shortness of breath, palpitations
☐ Headache, migraines, nausea, visual disturbances
☐ Convulsions, seizures
☐ Slurred speech, confusion, numbness, tingling around mouth
☐ Lack of body coordination (arms and legs)

Did you experience any of the following shortly before the first time you had the sensation of imbalance, disequilibrium, dizziness and/or vertigo:

☐ Forcefully coughed/sneezed, flying, diving
☐ Flu, cold, allergies, COVID
☐ Exposed to irritating fumes, paints
☐ Hadn't eaten in a long period of time
☐ Head trauma and injury (i. e., sport or motor vehicle accidents)
☐ Intense period of stress at work or in personal life

<u>Section 3:</u> The following questions refer to your general health status:

Do you suffer or have you been diagnosed with any of the following medical conditions? Please select all that apply:

☐ Chronic ear infections
☐ High/low blood pressure
☐ Liver diseases
☐ Parkinson's Disease
☐ Anemia/blood diseases
☐ Migraines
☐ Cancer treatments
☐ Genetic disorders
☐ Neurological disorders
☐ Head trauma/injury
☐ Other:

☐ Ménière's disease
☐ Heart diseases
☐ Kidney diseases
☐ Alzheimer's disease
☐ Diabetes
☐ Eye/vision problems

☐ Otosclerosis
☐ Respiratory problems
☐ G.I. track problems
☐ Stroke/Aneurysm
☐ High cholesterol

☐ Autoimmune disorders
☐ Endocrine disorders
☐ Arthritis/Rheumatoid disease
☐ Multiple Sclerosis

_____
_____
_____
_____
_____
_____

Are you on any prescription drugs for the above medical conditions? ☐ Yes ☐ No

- If Yes: **Please list:** _____
  _____
  _____
  _____

Are you a smoker? Yes No

- If Yes: **How many a day?** _____

Do you take St. John's Wort and/or Gingko Biloba daily? Yes No

Section 4: The following questions refer to your amplification history:

Have/do you wear hearing aids? Yes No **Skip to the end of case history form**

- If Yes: **Which ear?** Left Right Both

For how long did/have you had them? _____

Please describe the aspects of your hearing aid(s) that you like (i. e., comfortable, work well):

_____
_____
_____

Please describe what aspects of your hearing aid(s) you do not like or would change (i. e., uncomfortable, too loud/quiet, trouble with Bluetooth):

_____
_____
_____

Any additional you think we should know about your hearing:

_____
_____
_____
_____
_____
_____

Cellphones must be powered off when you enter the testing room as it can cause interference with the testing equipment.
Thank You