

# Complete Hearing

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Patient name: \_\_\_\_\_ Preferred first name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Please list all allergies: (To include but not be limited to: Food, Medications, Plastics, etc.) \_\_\_\_\_

Tobacco Use:  Past  Current  Never Use: Cigarettes Cigars Pipe Smokeless Vaping

Do you drink alcoholic beverages?  Yes  No How often: Daily Weekly Monthly Occasionally Rarely

Do you currently use recreational drugs?  Yes  No Which drugs & how often: \_\_\_\_\_

Have you experienced any of the following major medical problems? (Please list the approximate date of diagnosis)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Diabetes I or II        | <input type="checkbox"/> Malaria                          |
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Encephalitis            | <input type="checkbox"/> Measles                          |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Meningitis                       |
| <input type="checkbox"/> Blood Disorders/Thinner | <input type="checkbox"/> Genetic Disorders _____ | <input type="checkbox"/> Mumps                            |
| <input type="checkbox"/> Cancer _____            | <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Scarlet Fever                    |
| <input type="checkbox"/> Chicken Pox             | <input type="checkbox"/> Head/Neck Injury        | <input type="checkbox"/> Stroke                           |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> TMJ                              |
| <input type="checkbox"/> Dementia/Alzheimer's    | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Visual difficulties/disturbances |

List all significant medical history if it was not mentioned above: \_\_\_\_\_

Are you **currently** experiencing any of the following symptoms?

- Eye problems (such as blurred or double vision, pain)
- Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues)
- Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations)
- Respiratory issues (such as shortness of breath, cough, wheezing)
- Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain)
- Musculoskeletal issues (such as joint pain, swelling, recent trauma)
- Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness)
- Psychiatric issues (such as depression, anxiety, compulsions)
- Endocrine symptoms (such as frequent urination, hot flashes)
- Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands)
- Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency)

Comments related to symptoms mentioned above: \_\_\_\_\_

Has your hearing been previously tested?  Yes  No

If yes, please list when and the results, if known: \_\_\_\_\_

Why have you decided to have your hearing tested today? \_\_\_\_\_

When did you first notice a problem with your hearing?  Sudden Onset  Months Ago  Years Ago

Do you feel your hearing is better in one ear?  Yes  No If yes, which ear:  Right  Left

**ALMOST DONE... PLEASE FLIP OVER AND CONTINUE**

Regarding your ears/hearing, are you currently experiencing any of the following?

Dizziness

Unsteady/Balance struggles       Lightheadedness       True spinning sensations

Is it accompanied by:  Nausea    Ringing/Noises in ear(s)    Hearing loss    Visual disturbances    Other

Take a Vitamin D supplement:  Yes    No

Please describe *when* it happens, *how often*, *how long* & can you do anything to *alleviate* the symptoms?  
\_\_\_\_\_

Falling Down

How many falls in the past 12 months: \_\_\_\_\_

Have you been injured:  Yes    No   Describe: \_\_\_\_\_

Take a Vitamin D supplement:  Yes    No

Cerumen/Ear Wax Buildup       Right    Left

Ear Deformity       Right    Left

Ear Drainage       Right    Left

Ear Pain       Right    Left

Ear Pressure/Fullness       Right    Left

Family History of Hearing Loss

Who is the family member(s) & approximate age of known hearing loss: \_\_\_\_\_

History of Ear Infections       Right    Left

History of Noise Exposure

Please list the types of noise: \_\_\_\_\_

Did you wear hearing protection when exposed to these noises?       Yes    No

Itchy Ears       Right    Left

Previous Ear Surgery       Right    Left

What for & when: \_\_\_\_\_

Tinnitus/Ringing/Buzzing in the Ears       Right    Left

How long have you experienced it or When did it start? \_\_\_\_\_

Is it constant or does it come/go? \_\_\_\_\_

Do you notice it more during the day or night? \_\_\_\_\_

Please describe the sound: Pitch (high/low) / Roaring / Thumping / Crickets / Cicadas ? \_\_\_\_\_

Are there conditions/times you notice the sounds are worse? \_\_\_\_\_

How do the sounds affect your sleep mood / concentration abilities / anxiety? \_\_\_\_\_

If there are other medical experiences or symptoms regarding your ears that is not mentioned above? Please provide this information here: \_\_\_\_\_

**Thank you** for taking the time to fill out this form. Please sign below indicating that the information in this form has been read, understood, filled out completely & accurately to the best of your knowledge.

If someone other than the patient filled out this form, please sign below & state relationship to patient.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_