194 Pleasant St, Suite 1
Concord, NH 03301
(603) 415-3277
(603) 415-0055 fax

91 Hancock Rd, Suite 4A
Peterborough, NH 03458
(603) 547-1660
(603) 784-5477 fax

Alliance Hearing Center LLC /Alliance Hearing Aids LLC

AUDIOLOGY HISTORY FORM

Patient Name:_____ **Date of Birth:** _____ **Today's Date:**_____

How did you hear of us?
Circle all that apply

Website Google Facebook Radio Newspaper My Doctor Friend
Family Theatre Senior Kiosk Healthyhearing.com Insurance Other

Do you have difficulty understanding conversations:

In a quiet room…….	**Yes**	**No**	**Sometimes**
At a distance…….	**Yes**	**No**	**Sometimes**
When someone whispers……..	**Yes**	**No**	**Sometimes**
On the telephone……	**Yes**	**No**	**Sometimes**
In a restaurant…….	**Yes**	**No**	**Sometimes**
In the car……..	**Yes**	**No**	**Sometimes**
When several people are talking…….	**Yes**	**No**	**Sometimes**
With your doctor in the examination room……	**Yes**	**No**	**Sometimes**
At the checkout counter in a store……..	**Yes**	**No**	**Sometimes**
Do others complain that you set the television too loud?.....	**Yes**	**No**	**Sometimes**
Do others complain that you misunderstand conversations?.....	**Yes**	**No**	**Sometimes**
Do you hear the turn signal in the car?.....	**Yes**	**No**	**Sometimes**

Do you experience:

Lightheadedness……..……..……...……	**Yes**	**No**	**Sometimes**
Spinning sensations…….....	**Yes**	**No**	**Sometimes**
Imbalance……..	**Yes**	**No**	**Sometimes**

Do you experience tinnitus (noises in your ears/head)? ……..…….. **Yes** **No** **Sometimes**
All of the time_____ Often_____ If yes, which ear(s)_____

Do you have ear pain or a feeling of pressure? …….. **Yes** **No** **Sometimes**

Do you have a history of recurrent ear infections? …… **Yes** **No** **Sometimes**
Explain: as a child and/or currently? _____
If yes, when was your last infection? _____
In your lifetime, have you ever been exposed to loud noises? ……. **Yes** **No** **Sometimes**
Circle any of the following: Guns, Rifles, Factory Machines, Power Tools, Heavy Equipment, Trucks, Construction, Demolition, Concerts, and Music through earbuds/speakers, Other_____
For how long were you exposed to loud noises?_____
Did/do you wear hearing protection …… **Yes** **No** **Sometimes**

Have you had any surgery on your ear(s) ……..... **Yes** **No**
Explain: _____
Have you experienced any head trauma that resulted in a skull fracture or concussion? **Yes** **No**
Please explain:_____
Does anyone in your immediate family have a hearing loss or wear hearing aids? **Yes** **No**
Who & How long? _____
Have you recently seen or are you scheduled to see an Ear, Nose & Throat doctor? **Yes** **No**
If so, who and when? _____

**** <u>Certain medications and health conditions are known to be associated with hearing loss.</u>**
Circle any medications that you have taken:
Chemotherapy Drugs, "__Mycin" antibiotics, Aspirin, Quinine, Viagra, Cialis
Circle any condition that you have: High Blood Pressure, Heart Disease, Kidney Disease, Diabetes, STDs, Meniere's Disease, Hypothyroidism, Dementia