BOW RIVER HEARING

PATIENT INFORMATION

Confidential

Patient: _____ Health Care No: _____ Date: _____

Address: _____Postal Code: _____ Date of Birth: _____

Email: _____ Primary Contact Number: _____

Family Doctor: _____ Doctor's Phone Number: _____

How did you hear about our clinic: _____

SECTION ONE: HEARING HEALTH HISTORY

1. In your own words, please explain why you feel you need your hearing tested

   _____

   _____

   _____

2. How long have you noticed your difficulty of hearing and understanding? _____
3. Have you had your hearing tested before?

   When and where? _____

   What were the results? _____
4. Effects of hearing status towards your daily lives:
   a. Do you feel that you hear better one ear over the other ☐ Right ☐ Left ☐ No Difference
   b. Do others complain that the television is too loud? ☐ Yes ☐ No
   c. How well do you understand on the telephone? _____
   d. Which ear do you hear well with on the phone? ____Left ____Right ____Same
   e. Who do you have trouble understanding? ____Men ____Women ____Children
   f. Which scenarios create difficulties?

      ☐ 1-on-1 conversation ☐ 2 to 3 people talking at the same time

      ☐ Social gatherings ☐ Conversation with background noise

      ☐ Conversation while driving or riding in the car ☐ Meetings ☐ Church
6. Do you currently wear hearing aids? ☐ Yes ☐ No

   If yes, how do you do with your current aids? _____

   If no, have you tried any hearing aids before? ☐ Yes ☐ No

   What kind? ☐ Behind-the-Ear ☐ In-the-Ear When _____

SECTION TWO: MEDICAL CASE HISTORY

☐ Yes ☐ No Active pain or drainage in the ear

☐ Yes ☐ No History of ear infection within the past 90 days

☐ Yes ☐ No Sudden or fluctuating hearing loss within the past 90 days

☐ Yes ☐ No Unilateral (one-sided) hearing loss

☐ Yes ☐ No History of ear surgery [If yes, please give detail: _____]

☐ Yes ☐ No Family history of hearing loss [If yes, please give detail: _____]

☐ Yes ☐ No Acute or chronic vertigo or dizziness

If yes, what kind? ___Light Headedness ___Loss of Balance ___Room Spinning

Do you have nausea with it? ☐ Yes ☐ No

☐ Yes ☐ No Acute or chronic tinnitus (e.g. ringing or buzzing sounds in your ear[s])

If yes, which ear? ____Left ____Right

What kind? ____Ringing ____Buzzing ____Hissing ____Humming

How frequent? ____Constant ____Occasional

How Loud ____ loud ____ Medium _____ Soft

☐ Yes ☐ No Have you ever suffered a head injury?

If yes, please give details: _____

Did you lose consciousness: If yes, give details: _____

Did it affect your hearing? If yes, give details: _____

☐ Yes ☐ No Do you have a history of noise exposure?

If yes, what type? ____Recreational ____Occupational

How many years? _____ From year _____ to _____

Please describe the situation: _____

Do you ever use hearing protection in these situations? ☐ Yes ☐ No

5. Have you seen your physician recently? ☐ Yes ☐ No

   a. If yes, what for? _____ When is the follow up visit: _____

6. Do you suffer from: ____High blood pressure ____Diabetes ____Renal difficulties

   ____Stroke ____Cancer ____Vision impairment ____Arthritis

   Is there any other medical condition that I should be aware of?

   _____

7. What medications do you take regularly? ☐ Yes ☐ No

   (If you don't know the name, please indicate what they are for)

   _____