Nordstar Audiology II
Compassionate About Your Hearing
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417 Hill Road North - Pickerington, OH 43147

Patient Name:_______________________________________ **Date**:

1. Chief complaint: ❒ Hearing Loss (❒ Right ear/ ❒ Left ear/ ❒ Both) ❒ Tinnitus/Ringing ❒ Dizziness ❒ Difficulty hearing (❒ in Quiet ❒ in Noise) ❒ Telephone (❒ Right ear ❒ Left ear)

2. How long have you noticed this difficulty? ____

3. Do you think your hearing is changing? ❒ Yes ❒ No (❒ Gradual ❒ Sudden)

5. 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 ❒ Factory Noise
   ❒ Power Tools ❒ Military ❒ Jet Engines ❒ Other:

6. Do you have any of the following symptoms? ❒ Deformity of the ear ❒ Drainage of the ear ❒ Sudden or rapid loss within the past 90 days ❒ Acute or chronic dizziness/Imbalance ❒ Tinnitus(ringing) ❒ Ear pain

7. Have you ever had your hearing tested? ❒ Yes ❒ No If so, when was your last test? ___________________

8. Have you seen an Ear, Nose and Throat Physician? ❒ Yes ❒ No
   If so, who did you see? ___________________________________ When? ____________________

9. Have you ever had surgery that may have affected your hearing? ❒ Yes ❒ No Type? _________________

10. Who is your primary physician? ____

11. Would you like us to fax a copy of the hearing evaluation to your primary physician? ❒ Yes ❒ No

12. Is there a history of hearing loss in your family? ❒ Yes ❒ No If so, who? __________________________

13. Have you ever had an ear infection? ❒ Yes ❒ No (If yes, ❒ as a child ❒ as an adult)

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

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 ❒ Scarlet Fever
    ❒ Bell's Palsy ❒ High Blood Pressure ❒ Mumps ❒ Sinusitis
    ❒ Diabetes ❒ HIV ❒ Neurological ❒ Stroke/TIA
    ❒ Head Injury ❒ Malaria ❒ Symptoms ❒ Visual Trouble-Loss/Sight

16. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
    ____ Improved hearing in quiet ____ Improved hearing in noise
    ____ Cosmetic appearance ____ Expense

17. If you are currently using a hearing aid, or have in the past, please answer the following:
    Which ear is/was aided? ❒ Right ❒ Left ❒ Both
    How long have you used a hearing aid? ____