Cleartone Hearing Aid Services
and
Medina Hearing Aid Services

Patient Case History

Name: _____ Date:_____

Address: _____

Phone: Home# _____ Cell#:_____ Work#_____

Birth date: _____ Email Address: _____

Emergency contact person: _____

Relationship: _____ Phone: _____

Family Physician: _____

Otological History

How would you best describe your hearing? More than one may apply. Please check (√)

- o hearing is fine with no concerns
- o difficulty hearing in noisy environments
- o difficulty hearing in group situations
- o able to hear but not clearly
- o difficulty hearing from a distance
- o unable to hear

Have you ever experienced any of the following? Please check all that apply (√)

o excessive earwax o ear drainage/bleeding o ear pressure/fullness o ear pain
o swimmer's ear o popping sensation in the ear o fluctuating hearing loss
o fluid behind the eardrum o sensitivity to loud noises o dizziness/vertigo
o numbness in your hands o sudden change in vision o sudden change in hearing

o heart disease o stroke/TIA o diabetes/low blood sugar o high blood pressure
o hypothyroidism o asthma o mental illness o depression or anxiety
o migraines/severe headaches

o mumps o meningitis o measles o scarlet fever o HIV/AIDS o tuberculosis
o visual problems o hepatitis A, B or C o liver problems

o kidney or renal problems o chronic sinus infections o environmental allergies
o cancer o radiation/chemotherapy o long-term IV antibiotics o head trauma
o loss of consciousness o exposure to chemicals/solvents
o ear surgery o head or neck surgery o skull fracture or brain concussion

Please list your current prescriptions:

Medication	Reason
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Medina Hearing Aid Services, LLC
799 N. Court, Ste. 19, Medina, Ohio 44256
Tel: 330-725-1060

Do you experience ringing or other noises in your ears? ○ right ear? ○ left ear? ○ both ears?

Have you ever been exposed to noise at high levels (military, recreational, work)? ○ yes ○ no

If yes, did you or do you wear hearing protection? ○ yes ○ no

Do you feel that your hearing is better in one ear? ○ yes ○ no

If yes, which ear is better? ○ right ○ left

Have you previously had a diagnostic hearing test? ○ yes ○ no

If yes, how long ago? _____ Results? _____

When you leave the house where do you go? Please check (√)

Places you go	How often [number of times per week or month]?
○ work	_____
○ grocery store	_____
○ church	_____
○ doctor's office	_____
○ visit relatives/friends	_____
○ clubs/activities	_____
○ other	_____

Current or Former Occupation: _____Employed by:_____

Retired: Yes___ No___ Please describe what kind of work you did before you retired.

_____

_____

_____

_____

What do you hope will be the outcome of today's visit?

_____

_____

_____

How did you hear about us? _____

○ Coupon Book ○ Gazette ○ Phone Book ○ Sign ○ Town Money Saver ○Internet ○ Other

Friend/Relative: _____