MANATEE HEARING & SPEECH CENTER

HEARING HEALTH ASSESSMENT

Patient Name _____ Date _____

GENERAL HISTORY

When was your last hearing exam? _____ By whom? _____

What were the recommendations? _____

How long ago did you notice a decline in your hearing? ☐ Within past 90 days? ☐ 1–3 years ☐ 4–6 years ☐ 7–10 years ☐ 10+ years

Has anyone in your family suffered hearing loss? ☐ Yes ☐ No If yes, whom? _____

Do you have a history of any of the following:

Earaches	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No	Pain/Discomfort	☐ Yes ☐ No
Allergies to plastic	☐ Yes ☐ No	Head injury	☐ Yes ☐ No	Cerumen buildup	☐ Yes ☐ No
Drainage	☐ Yes ☐ No	Noise exposure	☐ Yes ☐ No	Excessive noise exposure	☐ Yes ☐ No
Ringing in ears	☐ Yes ☐ No	PE Tube(s)	☐ Yes ☐ No		

MEDICAL HISTORY

Diabetes	☐ Yes ☐ No	Radiation therapy to local area	☐ Yes ☐ No	Currently on blood thinners	☐ Yes ☐ No
Regular MRIs?	☐ Yes ☐ No	Chemotherapy within 6 months	☐ Yes ☐ No		
TMJ	☐ Yes ☐ No	Compromised immune system	☐ Yes ☐ No		

Allergies to any medications _____

Have you ever had ear surgery? ☐ Yes ☐ No If yes, which ear? ☐ Left ☐ Right

Type _____

Please list other medical conditions: