

Complete Hearing



4200 pioneer woods drive | lincoln ne 68506 | 402/489-4418 | (f) 402/489-2268 | complete-hearing.com

Patient name: _____ Preferred first name: _____ Birthdate: _____

Please list all allergies: (To include but not be limited to: Food, Medications, Plastics, etc.) _____

Do you currently use any tobacco products? Yes No Use: Cigarettes Cigars Pipe Smokeless

Do you drink alcoholic beverages? Yes No How often: Daily Weekly Monthly Occasionally Rarely

Do you currently use recreational drugs? Yes No Which drugs & how often: _____

Have you experienced any of the following major medical problems? (Please list the approximate date of diagnosis)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> High Fevers | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Influenza | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Malaise | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Malaria | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Head/Neck Injury | <input type="checkbox"/> Measles | |

List all significant medical history if it was not mentioned above: _____

Are you currently experiencing any of the following symptoms?

- Eye problems (such as blurred or double vision, pain)
- Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues)
- Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations)
- Respiratory issues (such as shortness of breath, cough, wheezing)
- Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain)
- Musculoskeletal issues (such as joint pain, swelling, recent trauma)
- Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness)
- Psychiatric issues (such as depression, anxiety, compulsions)
- Endocrine symptoms (such as frequent urination, hot flashes)
- Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands)
- Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency)

Comments related to symptoms mentioned above: _____

Has your hearing been previously tested? Yes No

If yes, please list when and the results, if known: _____

Why have you decided to have your hearing tested today? _____

When did you first notice a problem with your hearing? Sudden Onset Months Ago Years Ago

Do you feel your hearing is better in one ear? Yes No If yes, which ear: Right Left

ALMOST DONE... PLEASE FLIP OVER AND CONTINUE

Regarding your ears/hearing, are you currently experiencing any of the following?

- Dizziness – Unsteady/Balance struggles
- Dizziness – Lightheadedness
- Dizziness – True spinning sensations
- Dizziness – Falling down

If you answered yes to any of the above *Dizziness Symptoms*: Please describe when it happens, how often, how long & can you do anything to alleviate the symptoms? _____

- Cerumen/Ear Wax Buildup Right Left
- Ear Deformity Right Left
- Ear Drainage Right Left
- Ear Pain Right Left
- Ear Pressure/Fullness Right Left
- Family History of Hearing Loss

Who is the family member(s) & approximate age of known hearing loss: _____

- History of Ear Infections Right Left
- History of Noise Exposure

Please list the environments: _____

Did you wear hearing protection when exposed to these noises? Yes No

- Itchy Ears Right Left
- Previous Ear Surgery Right Left

What for & when: _____

- Tinnitus/Ringing/Buzzing in the Ears Right Left

How long have you experienced it or When did it start? _____

Is it constant or does it come/go? _____

Do you notice it more during the day or night? _____

Please describe the sound: Pitch (high/low) / Roaring / Thumping / Crickets / Cicadas ? _____

Are there conditions/times you notice the sounds are worse? _____

How do the sounds affect your sleep mood / concentration abilities / anxiety? _____

If there are other medical experiences or symptoms regarding your ears that is not mentioned above? Please provide this information here: _____

Thank you for taking the time to fill out this release. Please sign below indicating that the information in this form has been read, understood, filled out completely & accurately to the best of your knowledge.

If someone other than the patient filled out this form, please sign below & state relationship to patient.

Signature: _____ Date: _____