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.)_____

_____

Tobacco Use: ☐Past ☐Current ☐Never Use: Cigarettes Cigars Pipe Smokeless Vaping

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)

☐AIDS/HIV
☐Anxiety
☐Arthritis
☐Blood Disorders/Thinner
☐Cancer _____
☐Chicken Pox
☐Depression
☐Dementia/Alzheimer's
☐Diabetes I or II
☐Encephalitis
☐Fatigue
☐Genetic Disorders _____
☐Headaches/Migraines
☐Head/Neck Injury
☐Heart Problems
☐High Blood Pressure
☐Malaria
☐Measles
☐Meningitis
☐Mumps
☐Scarlet Fever
☐Stroke
☐TMJ
☐Visual difficulties/disturbances

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 ☐Lightheadedness ☐True spinning sensations

Is it accompanied by: ☐Nausea ☐Ringing/Noises in ear(s) ☐Hearing loss ☐Visual disturbances ☐Other

Take a Vitamin D supplement: ☐Yes ☐No

Please describe *when* it happens, *how often*, *how long* & can you do anything to *alleviate* the symptoms?

_____

☐Falling Down

How many falls in the past 12 months: _____

Have you been injured: ☐Yes ☐No Describe: _____

Take a Vitamin D supplement: ☐Yes ☐No

☐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 types of noise: _____

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 form. 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:_____