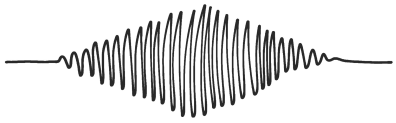

MaryAnn Pladdys, Au.D.

Patient Name: _____ Date: _____

Date of Birth: _____ Primary Care Physician: _____

Reason for Today's Visit: _____

_____

Do you have hearing loss? Yes No Unsure

Which is your better ear? Right Left Both are the same

Occupation: _____

Are you exposed to loud noise at work? _____

Have you ever been exposed to loud noise? _____

Do you have ringing, buzzing or other noises (tinnitus) in one or both of your ears? Yes No

If yes, please describe it: _____

Is it constant or intermittent? _____

Does it keep you awake at night? Yes No

Have you been diagnosed with hearing loss? Yes No At what age? _____

Are there members of your family who have hearing loss? _____

_____

Do you have a history of ear infections/drainage/ear surgery? Yes No

Please describe: _____

Do you experience fullness or stuffiness in one or both of your ears? Yes No

Please describe: _____

Do you experience facial weakness, numbing or tingling? Yes No

Please describe: _____

Please list any medications you are taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you had any of the following?

___ Arthritis
___ Allergies
___ Bell's Palsey
___ Cancer
___ Concussion/Skull Fracture
___ Dementia/Alzheimer's
___ Depression/Anxiety
___ Diabetes Type I
___ Diabetes Type II
___Hepatitis
___ High Blood Pressure
___ High Fevers
___ HIV
___ Measles
___ Meningitis
___ Mumps
___ Multiple Sclerosis
___ Pacemaker
___ Parkinson's Disease
___ Scarlet Fever
___ Seizures
___ Stroke/TIA
___ Tuberculosis
___ Vision Problems

Have you had any recent changes in your functioning or behavior, such as acting out, irritability, fights at home or work? Yes No

Please describe: _____

_____

Do you have difficulty hearing or understanding during any of the following:

___ Watching TV ___ Dining in Restaurants ___ Meetings

___ Speaking on the Phone ___ Movies ___ Religious Services

Do you feel that people mumble when they speak? Yes No

Which ear do you use on the phone? Right Left

Have you fallen in the past 12 months? Yes No

How many times have you fallen? _____

Were you injured? _____

Do you take a vitamin D supplement? Yes No

Do you feel safe at home? Yes No

Have you felt down, depressed or hopeless in the past few months? Yes No

Have you ever used a hearing aid? Yes No

Do you use a hearing aids now? Yes No

How long have you been wearing your current aids? _____

Do you wear it/them regularly? Yes No

Do you feel the aids are working well for you? Yes No

List any problems you are having with your current hearing aids:

_____

_____

What would you improve with your current hearing aids?

_____

_____

Is there any other information that we should know that we can help you with?

_____

_____