Date: __/__/__

Lafayette Hearing Center
Case History

Patient Name: _____ DOB: ____/____/____ Age: _____
First Middle I Last

Address: _____City _____Zip _____ □ Male □ Female

Insurance: _____ Home Phone:_____ Cell Phone _____

Occupation: _____ Email: _____

Companion: _____ Companion phone: _____ Relationship: _____
I am comfortable with: □ Text □ Phone □ Email
May we occasionally ask for your feedback on your visit(s) with us? □Yes □ No

Medical History	Yes	No	Details
Middle ear infections?			
Ear Surgery?			
Stuffy or fullness in ears?			
Ear Pain?			
Sinus/Allergies?			
Frequent ear aches/draining ears?			
Head or face injury?			
Ringing/buzzing in ears? RT ___ LT____ Both ____			
Balance problems? (spinning □, unsteady □, acute □)			
High Blood Pressure?			
Diabetes? Insulin ___ Pills____ Diet ____			
Kidney disease? Take water pill?			
Do you take regular aspirin? Dosage ____ How many? _____			
Do you use tobacco products?			

Any current medical diagnosis? i.e. Heart disease, stroke, high cholesterol, etc. _____

_____

When did you first notice a hearing problem?
□ Recently □ 1-3 years □ 4-6 years □ 7-10 years □ + 10 years

Is one ear better than the other? □ Y □ N If yes, which ear? **□ R □ L**

Which ear do you use for the telephone? □ R □ L

Do people in your family think you have trouble hearing? □ Y □ N If yes, who? _____

Does anyone else in your biological family (i.e. siblings, parents) have hearing problems? □ Y □ N

If yes, who? _____

Do you or have you worked in a noisy place? □ Y □ N **Do you have noisy hobbies? □ Y □ N**
Notes:_____

List *all* medications/herbal supplements, dosage, frequency & route (e.g. oral, suppository, shot); check if list attached □_____

_____

_____

In office only: Medications reviewed for __ tinnitus, __ HL, __ vertigo/dizziness

Complete other side also →

Please tell us 3 listening situations where you wish you could hear better:

1. _____

2. _____

3. _____

Office notes: