SHARP HEARING

801-484-3277
Fax: 801-666-2027

140 West, 2100 South, Suite 120 - Salt Lake, UT 84115

Confidential Patient History - Dated:

Patient Name: **Birth Date:**
Address:
City: **State:** **Zip Code:**

Please complete the following:

MEDICAL HISTORY:

Yes No Have you seen a doctor in the past six months? (Dr. _____)
Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, give date _____
Yes No Have you ever had your hearing tested?
If yes, give date _____ by whom _____
Yes No Have you ever had any type of ear surgery?
If yes, type of surgery _____(Dr. _____)
Yes No Do you take medicine every day?
For what condition? _____
Yes No Do you have any other medical conditions?
If yes, explain _____
Yes No Are you hypertensive?; Yes No Nervous?; Yes No Have a heart condition?

ABOUT YOUR EARS: Do you have any of these symptoms?
Yes No Deformity of the ear
Yes No Drainage from the ear
Yes No Sudden or rapid loss of hearing in the past 90 days
Yes No Acute or chronic dizziness
Yes No Which is your poorer ear? Same Right Left
Yes No Have you ever seen a doctor for wax removal?
Yes No Do you ever have pain in your ears?

ABOUT YOUR HEARING: Do you experience difficulty with the following?
Yes No Understanding conversation
Yes No Hearing in a crowd
Yes No Hearing by telephone
How long have you had a hearing problem? _____
Yes No Does anyone else in your family have a hearing problem?
What relationship? _____
Yes No Do you now or have you ever worn a hearing aid?
If yes, how do you think you may be helped? _____

Who referred you to us? _____

Signature _____ Date _____