PREMIERE SPEECH AND HEARING

Your Preferred Communication Experts

PERSONAL HISTORY - ADULT

Full Name: _____

Date of Birth: _____

Reason for Today's Visit: _____

MEDICAL HISTORY

Medications: (including prescription, over-the-counter, herbal supplements).

Drug Name	Dosage	Frequency	Route

Have you had any of the following? Please check all that apply.

☐	Ear pain	☐	Ear infections	☐	Ear popping
☐	Ear drainage	☐	Ear surgery	☐	Ear tubes
☐	Ear ringing	☐	Trauma (head/ear)	☐	Diabetes
☐	Genetic Disorder	☐	Craniofacial Anomalies	☐	Dizziness or unsteadiness
☐	Arthritis	☐	Memory Loss	☐	Alzheimer's or Dementia
☐	Autoimmune Disease (i.e., HIV, Lupus)	☐	Cancer	☐	Meningitis
☐	Measles/Mumps	☐		☐	

List any operations with date of occurrence: _____

_____

Other chronic illnesses: _____

Any drug or other allergies: _____

HEARING HEALTH HISTORY

Please check if you are experiencing: ☐ Hearing Difficulty ☐ Balance Problems ☐ Tinnitus

Do you hear people speaking but have difficulty clearly understanding what is being said? ☐ yes ☐ no

When did you first notice a hearing problem? _____**Was it** ☐ gradual ☐ sudden ☐ fluctuating

What do you feel caused your hearing problem? _____

Have you seen a physician for your hearing problem? ☐ Yes ☐ No **If yes, whom and when**_____

_____

Have you experienced any of the following:	Occasionally	Often	Always
Family/friends notice that you aren't hearing well?	☐	☐	☐
Family/friends report that you have the TV volume too loud?	☐	☐	☐
Do you ask people to repeat themselves?	☐	☐	☐
Difficulty hearing on the telephone?	☐	☐	☐
Difficulty hearing soft or distant voices?	☐	☐	☐

Do any family members have a hearing problem? ☐ Yes ☐ No

If yes, whom and what age was it identified? _____

Is hearing loss causing any issues at work? ☐ Yes ☐ No

Please indicate all of the situations where you have been exposed to loud noises:

☐ Work ☐ Home ☐ Hobbies ☐ Shooting guns ☐ Loud Music ☐ Other: _____

Did you wear hearing protection: ☐ Yes ☐ No

Please check any of the following situations where you notice hearing difficulty: ☐ Television ☐ Radio

☐ Movies ☐ Place of Worship ☐ At a table with 4-6 people ☐ In noisy restaurants ☐ At a party

HEARING AID HISTORY

Have you ever worn a hearing aid(s)? ☐ Yes ☐ No **If yes, which ear(s)?** ☐ Right ☐ Left ☐ Both

What style are your hearing aid(s)? _____

When and where did you purchase the present hearing aid(s)? _____

Have the hearing aids been ☐ satisfactory or ☐ unsatisfactory, and why? _____

_____

Please rate the following in order of importance to you (1 - Most Important, 3 - Least important)

	Ability to hear as well as I can
	Cosmetics - whether others can see them
	Price

Any other questions or comments? _____

_____

_____