Lagniappe HEARING

Angela Ponthier, Au.D.

PATIENT HISTORY

Patient Name ____ DOB: ______ /______ /________
First MI Last MM DD YYYY

Reason for your visit today? ____

____

Medical / Audiological History

How is your general health? ____

Recent hospitalization or surgeries? ____

History of diabetes? ☐ Yes ☐ No Explain: ____

History of ear disease? ☐ Yes ☐ No Explain: ____

Family history of hearing loss? ☐ Yes ☐ No Explain: ____

Present medications: ____

History of trauma to the head? ☐ Yes ☐ No Explain: ____

Do you have: ☐ Dizziness ☐ Vertigo ☐ Loss of balance ☐ Nausea

Describe: ____

When did it begin? ______________________ What duration? ______________________

How often does it occur? ____

Is it ever accompanied by nausea and / or vomiting? ____

Do you have Tinnitus? (ringing, buzzing, hissing in the ears) ☐ Yes ☐ No

☐ Left Ear ☐ Right Ear ☐ Both Ears Since when? ____

How frequent? ______________________ Duration: ______________________

Describe: ____

History of noise exposure? ____

Have you ever worn hearing aids? ☐ Yes ☐ No

Hearing Difficulty Questionnaire

Listening Situations	Hearing Quality			Importance		
	Poor		Normal	Not	Somewhat	Very
One on one conversation	1	2	3	1	2	3
Viewing or listening to television	1	2	3	1	2	3
Leisure activities	1	2	3	1	2	3
Restaurants	1	2	3	1	2	3
Church	1	2	3	1	2	3
Group meetings	1	2	3	1	2	3
Workplace / Office	1	2	3	1	2	3
Telephone / Cellphone	1	2	3	1	2	3
Driving or riding in a car	1	2	3	1	2	3
Male voice	1	2	3	1	2	3
Female voice	1	2	3	1	2	3
Children’s voices	1	2	3	1	2	3
Other (indicate) ______________	1	2	3	1	2	3

____ ______________
Patient’s Signature Date

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