BROOKWAY

HEARING CENTER

CONFIDENTIAL CASE HISTORY

Date_____ Name_____

Address_____

City_____ State_____ Zip_____

Phone_____ Date of Birth_____

Marital Status: □ Single □ Married □ Widowed

Occupation_____ (current or retired)

Email address_____

Primary Care Physician_____

How did you hear about us? □ Relative/Friend □ Newspaper □ Mail □ TV

□ Doctor □ Phonebook □ Internet □ Other_____

Observing Party Name_____ (spouse, daughter, son, friend, other)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Brookway Hearing, Notice of Privacy Practices. I have read and understand the health information, and other concerns regarding my health information.

_____

Patient Signature

BROOKWAY HEARING CENTER

MEDICAL HISTORY

Have you seen a doctor specializing in diseases of the ear in the last six month? □Yes □No

If yes to question above, please give doctor's name and date seen._____

Have you been diagnosed with any of the following?

Otosclerosis □Yes □No | Cholesteatoma □Yes □No | Labyrinthitis □Yes □No

Meniere's Disease □Yes □No | Barotrauma □Yes □No | Permanent hearing loss □Yes □No

Bell's Palsy □Yes □No | Acoustic neuroma □Yes □No | Ossicular dislocation/fixation □Yes □No

Please check any of the following that you currently have or have had in the past:

___Arthritis	___Heart Disease	___Measles	___Parkinson's Disease
___Asthma	___Hepatitis	___Meningitis	___Sinusitis
___Diabetes	___HIV	___Stroke/TIA	___High Blood Pressure
___Head Trauma	___Vision Loss	___Cancer	___Neurological Problems
___Migraines	___Seizure Disorder	___Scarlet Fever	___Temporomandibular Joint Disorder (TMJ)

Have you ever had any type of EAR surgery? □Yes □No

If yes to the question above,

When? _____ By Whom? _____ What type of surgery? _____

Do you take any prescription medications? Please list: (If list is extensive, we can make a copy)

Medication:_____ Reason:_____

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Medication:_____ Reason:_____

Do you take **Aspirin** or any **Blood Thinners**? □Yes □No

Do you have any of these symptoms?

Deformity of the ear?..... □Yes □No

Sudden or rapid hearing loss?..... □Yes □No

Hearing loss in one ear in the last 90 days?..... □Yes □No

Discharge from ear in the past 90 days?..... □Yes □No

Do you have any pain in your ear?.....□Yes □No

Episodes of Dizziness?.....□Yes □No

Have you ever seen a doctor for wax removal?..... □Yes □No

Which ear your poorer ear?..... □ Left □ Right □ Same

HEARING HISTORY

Do you think you have hearing loss? □ Yes □ No

If yes, How long have you been having difficulty? _____

Have you ever had your hearing tested? □ Yes □ No

If yes, When? _____ By Whom? _____

What were the findings? _____

Do you wear hearing aids now? □ Yes □ No

If yes, when did you get them? _____ Where did you get them? _____

Were you in the Military? □ Yes □ No

If yes, were you exposed to gunfire? □ Yes □ No

If yes, What type? □ Rifle □ Artillery □Tanks

Does anyone else in your family have a hearing problem? □ Yes □ No

If yes, What is their relationship to you? _____

Do you feel your hearing has changed? □Yes □No

If yes, □ Gradual □Sudden

Do you or have you experienced any of the following?

Ear pressure/fullness?..... □Yes □No

Ear pain?..... □Yes □No

Swimmer's ear?..... □Yes □No

Popping Sensation in the ear?..... □Yes □No

Fluctuating hearing loss?..... □Yes □No

Difficulty hearing on the telephone?..... □Yes □No

Do you experience difficulty with…

Hearing in a crowd or other noisy situations where background noise is present? □Yes □No

Understanding all the words in conversation clearly? □Yes □No

Please rank the following in order of importance using 1 – 4 (1 being the most important and 4 being least important. Example: if cosmetic appearance is the most important it should be given a number 1 and if expense is the least important then it should be given a number 4):

_____Improved hearing in quiet

_____Improved hearing in noise

_____Cosmetic appearance

_____Expense