Professional Hearing Services
9011 N. Meridian St Suite 205
Indianapolis, IN 46260

Patient Name
First MI Last

Date of Birth
MM/DD/YYYY

TELL US ABOUT YOUR MEDICAL AND HEARING HEALTH HISTORY

Do you experience hearing loss? When/where was your last hearing evaluation?

☐ Yes ☐ No ☐ Not Sure

☐ Never Evaluated

Please describe your hearing challenges and hearing goals:

How long have you noticed changes in your hearing?

☐ Recent ☐ within months ☐ 1-5 years ☐ 5 + years ☐ Family History

Do you use assistive listening devices or have a history of wearing hearing devices?

Please check all that apply/ Incl. Comments

☐ Tinnitus/Ringing ☐ Left Ear ☐ Right Ear
☐ Constant ☐ Intermittent Sounds like:

☐ Vertigo ☐ Noise Exposure List / Describe Below:
Accompanied By:
☐ Lightheaded
☐ Limb weakness/ tingling
☐ Tinnitus

☐ Decline in ability to focus
☐ Depression
☐ Changes in memory
☐ Increased listening effort
☐ Imbalance
☐ Diabetes (insulin/pills)

☐ Diabetes (uncontrolled)
☐ Ear infections/drainage
☐ Ear Surgeries
☐ Thyroid Issues
☐ Seasonal Allergies
☐ TMJ

☐ High Blood Pressure
☐ Heart/vascular issues
☐ Stroke
☐ Double vision
☐ Macular degeneration
☐ Recent hospitalization

☐ Blood Thinners
☐ Pacemaker
☐ Radiation
☐ Chemotherapy
☐ Genetic disorder
☐ Autoimmune disease

NOTES:

Please list current medications:

Please list all allergies (food, medication, plastics etc.):