



Hearbright, an Audiology Corporation

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MEDICAL HISTORY

Last Name:		First Name:	
Date of Birth:	Age:	Current or Former Occupation:	
Referred By: (Physician's Name)			
Signature for release of medical information to above physician:			
If patient is a minor, print your name and relationship to patient:			

What is the reason for your hearing test today?

Please mark, circle, or briefly explain your main concern regarding your ears or hearing:

Yes/No	Description	Specify	When did symptom begin?	Comment
Yes/No	Gradual Hearing Loss?	Right Ear Left Ear (circle one or both)		
Yes/No	Sensation of "Plugged Ear"?	Right Ear Left Ear (circle one or both)		
Yes/No	Dizziness (Sensation of Spinning and Falling)?	Constant or Sometimes?		
Yes/No	Feeling of Imbalance?	Constant or Sometimes?		
Yes/No	Ear Pain?	Right Ear Left Ear (circle one or both)		Constant Sometimes (circle one or both)
Yes/No	Ringling or Buzzing in Ear?	Right Ear Left Ear (circle one or both)		Constant Sometimes (more than 10 min duration) (circle one or both)
Yes/No	History of Ear Infections?	Right Ear Left Ear (circle one or both)		
Yes/No	Noise Exposure?	Firearms, Firecrackers, Machinery, Trucks/Engines Speakers	Are you still engaging in described activity?	
Yes/No	Family History of Hearing Loss or Ear Problems?	Hearing loss during later years in life Ear Surgery Deafness (circle one)	Mother Father Siblings Other	
Yes/No	Ear Surgery	Right Ear or Left Ear?	When?	Type of Surgery
Yes/No	Head Trauma		When?	
Yes/No	History of Hearing Aid Use?	Right Ear Left Ear (circle one or both)	When?	Describe: