Roseville Diagnostic Hearing Center

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Roseville, CA 95661
P (916) 780-4200 f (916) 780-4201

Today's Date:_____

Last Name:_____ **First Name**:_____

Date of Birth:_____ **Gender**:_____ **Primary Language**:_____

Referred by:_____**Reason for referral**?_____

How did you hear about us? *(Please check **all** that apply)*

[ ] Doctor [ ] Family Member [ ] Friend [ ] Newspaper [ ] Internet [ ] Sign [ ] Facebook

[ ] Health Fair [ ] Open House [ ] Website [ ] Phone Book [ ]Other_____

Please check any of the following that applies to you:

[ ] Difficulties with hearing as an adult. How many years?_____ Which ear? Right Left Both

[ ] Is your hearing changing: Gradually Fluctuating Sudden (date of onset)_____

[ ] Difficulties hearing as a child. List causes_____

[ ] Difficulties hearing in background noise. Since when?_____

[ ] Difficulties hearing on the telephone. Which ear do you use on the phone?_____

Do family members or friends tell you that you are "not listening"?_____

Have you had a hearing test before? [ ] YES [ ] NO If yes, when:_____ Results_____

Have you worn any hearing aids before? [ ] YES [ ] NO If yes, when:_____ [ ] Right ear [ ] Left ear [ ] Both

Where did you purchase your hearing aid(s):_____

[ ] Frequent colds, chronic sinus congestion or infection

[ ] Seasonal allergies or allergies. What type?_____

[ ] Noise in the ears/Tinnitus: Right ear Left ear Both Since when:_____

Describe the noise in the ears_____ Constant or Periodic?_____

[ ] Dizziness or loss of balance, since when?_____ Is your physician aware of this?_____

[ ] Vertigo, Since when?_____ Is your physician aware of this?_____

[ ] Feeling of fullness in ears, since when?_____ Ear pain? Since when?_____ Right Left Both

[ ] Drainage in ears, since when?_____ Right ear Left ear Both Ears

Do you have any <u>severe illness</u> or <u>major medical</u> conditions? Please list_____

_____

Do you have any of the following?

[ ] Diabetes	**[ ] Thyroid Condition**	**[ ] High Cholesterol**	**[ ] Heart Problems**
[ ] Stroke	**[ ] High Blood Pressure**	**[ ] Depression**	**[ ] Anxiety**
[ ] Headaches	**[ ] Cancer**	**[ ] TMJ**	**[ ] Visual Problems**
[ ] Meningitis	**[ ] Bell's Palsy**	**[ ] Genetic Disorders**	**[ ] Endocrine problems**

[ ] Head Trauma, provide details_____

[ ] Ear Surgery, provide details_____

[ ] Exposure to noise (work-related, military service, recreational, concerts) _____

_____

Any additional Comment or questions for the audiologist:_____

_____