HEARING INNOVATIONS
Health Information

Name_____ Date_____
Email Address_____

	Yes	No
Have you had an exam by your physician in the last six months?	____	____
Examination by an ENT physician? (Ear, Nose, & Throat physician) _____	____	____
Ear Physician's Name: _____		
Are you Diabetic? _____	____	____
High Blood Pressure?	____	____
Do you smoke? _____	____	____
Had any head or neck trauma? _____	____	____
Headaches?	____	____
Facial Numbness?	____	____
Pressure or fullness in your ears? _____	____	____
Wax removed from your ears? _____	____	____
How often?_____		
Dizziness or vertigo?	____	____
Have you fallen in the last 12 months? _____	____	_____
If yes, were you injured?	____	____

	Yes	No
Any pain in or around your ears?	____	____
Had ear surgery? What kind?_____	____	____
Punctured Ear Drum?	____	
Family History of Hearing loss?	____	
Noise Exposure?	____	____
Drainage from your ears?	____	
Acoustic Trauma? (punctured ear drum)	____	
CT scan or MRI of Head or ears?	____	____
Do you have Hearing Loss?	____	____
Which ear is worse?	R___	L___
Sudden Hearing Loss? When?_____	____	
Do you wear Hearing Aids?	____	
Right____Left____Both____		
How long have you worn Hearing Aids? _____		
Tinnitus? (Ringing or head noise)____		