Tobias Hearing Center
382 Quincy Avenue, Quincy MA 02169
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Stephen P. Tobias, HIS | MA License #59

Medical History

Date: _____

Patient Information

Patient Name

_____Birth Date _____/_____/_____

Do you have pain/discomfort in your ear[s] Yes: _____ No: _____

Do you have any drainage in your ear[s] Yes: _____ No: _____

Hearing History

Have you had a sudden or rapid loss of hearing in the past 90 days? Yes: _____ No: _____

Do you have ringing or other noises in your ear[s] - Tinnitus? Yes: _____ No: _____

Do you have acute or recurring dizziness or vertigo? Yes: _____ No: _____

Have you seen your physician regarding any of the above? If so, when?_____

Have you ever had ear surgery? Yes: _____ No: _____

When was the first time you noticed difficulty hearing? _____

Complete the following if you currently have a hearing aid[s]

Have you had a hearing test before? Yes: _____No: _____When: _____Results:_____

In which ear is your hearing the worse? Right: _____ Left: _____ Same:_____

Have you noticed that people seem to mumble? Yes: _____ No: _____

Do you find yourself asking people to repeat what they have said? Yes: _____ No: _____

Do you sometimes hear words but do not always understand them: Yes: _____ No: _____

Do you find it difficult to hear in noisy places? Yes: _____ No: _____

Have you been told that you speak loudly? Yes: _____ No: _____

Have you been told that you turn the volume on the TV up too loud? Yes: _____ No: _____

Do you have to strain to understand young children's voices? Yes: _____ No: _____

_____

How often do you wear your hearing aid[s]_____ How old is/are your hearing aids _____

Do you wear hearing aids in both ears? Yes: _____ No: _____

Where were you fit with the hearing aids[s] _____

When wearing your hearing aids[s], do you have difficulty understanding in crowds? Yes: ____ No:____

Do your hearing aids make your ears sore? Yes: _____ No: _____

Do your hearing aids whistle? Yes: _____ No: _____

Do you repair your hearing aids often? Yes: _____ No: _____

What is the greatest problem with your hearing aids? Yes: _____ No: _____

On a scale of 1 to 10, rate your satisfaction level with hearing aids [1=poor, 10=excellent] _____