

Thank You for choosing Richmond Hearing Doctors! Please complete the front AND back of this form. If you have a list of your current medications, we can copy that and you can skip question #15.

Name: _____ **Date of Birth:** _____ **Date:** _____

1. What is your **primary reason** for this appointment? _____

2. Do you feel you have any **difficulty** hearing? Yes No
If yes, which ear? Right Left Both
If yes, which ear has **better** hearing? Right Left Equal
If yes, what is known or suspected **cause** of hearing difficulty? _____

3. Have you ever had a **hearing test**? Yes No
If yes, when and where? _____

4. Do you have any **family members** with hearing loss or other ear-related issues? Yes No
If yes, please describe: _____

5. Do you have **tinnitus, ringing, noises, or buzzing** in your ears? Yes No
If yes, which ear? Right Left Both
If yes, is it: Constant Periodic – how often: _____
If yes, describe it: Ringing Buzzing Chirping Static Pulsating
 Hissing Other: _____

6. Do you have **dizziness or vertigo**? Yes No
If yes, describe: _____
If yes, do you have nausea? Yes No
If yes, are you under the care of a doctor? Yes (Doctor's Name: _____)
 No

7. Do you have a history of **ear infections or ear surgeries**? Yes No
If yes, please describe: _____

8. In the last 90 days, please check if you have had any of the following: None of the below
 Ear pain/discomfort Right ear Left ear Both ears
 Ear drainage Right ear Left ear Both ears
 Fullness/pressure in ears Right ear Left ear Both ears

9. Do you have a history of **noise exposure** at any time in your life? Yes No
If yes, check all that apply: Loud concerts/music Military-related noise Firearms
 Farm equipment Power tools Industrial machinery
 Other: _____

7301 Forest Avenue
Suite 202
Richmond, VA 23226
804-282-0022



13925 Coalfield Commons Place
Suite 101
Midlothian, VA 23114
804-818-0000

10. Do you currently, or have you ever, worn **hearing aids**? Yes No
If yes, when and where did you purchase them? _____
If yes, were you/are you satisfied? Yes No
Comments: _____

11. Do you feel you **need** hearing aids/new hearing aids? Yes No

12. Please check all **medical conditions** that apply: None
 Diabetes High Blood Pressure Cancer Head Injury Serious Infection
 Stroke Vision Problems Arthritis Other: _____

13. Have you used **tobacco products** (cigarette, cigar, smokeless tobacco) one or more times in past 24 months?
 Yes No
If yes, how often and what type? _____

14. Please provide any other information about your **general health or hearing health** that you feel may be helpful to today's appointment: _____

15. Please list current **medications** including all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary/nutritional supplements:
Medication: Dosage: Frequency:

16. Please provide the names of all your current physicians:
Physician: Specialty:

Signature

Date