CODY AUDIOLOGY CLINIC
Dr. Brandi R. Shepard

Medical History Form

902 Blackburn St • Cody, WY 82414 • P: 307-578-2976 • www.codyhears.com

Name: (Last) (First) Age: Date:

1. What is the primary reason for today's visit?

2. Are you experiencing problems with your hearing? ◯ Yes ◯ No

   Which Ear? ◯ Both ◯ Right ◯ Left

3. Has the hearing loss been: ◯ Gradual ◯ Sudden ◯ Fluctuating

4. How long have you noticed problems with your hearing?

   ◯ Recently ◯ 1-3 years ◯ 4-6 years ◯ 7-10 years ◯ More than 10 years

5. What do you think may have caused this?

   5a. Do you hear better out of one ear? ◯ Right hears better ◯ Left hears better ◯ They are the same

6. Have you had your hearing tested before? ◯ Yes ◯ No

   If *Yes*, when?

7. What was the outcome of your previous hearing test? ◯ No Loss ◯ Mild Loss ◯ Hearing Aids

8. Do you currently use a hearing aid(s)? ◯ Yes ◯ No

9. Have you ever used a hearing aid(s)? ◯ Yes ◯ No

   (If you answered NO, please move on to question #10)

   9a. Style and make of hearing aid(s):

   9b. How often do you wear your hearing aid(s)?

   9c. What do you like most about your hearing aid(s)?

   9d. How could your hearing aid(s) be better?

10. Do any members of your family have a hearing problem? ◯ Yes ◯ No

11. Do you have a history of ear infections? ◯ Yes ◯ No

12. Have you had any of the following in the last six months? (Circle all that apply)

    ☐ Medically diagnosed ear pathology ☐ Ear Pain ☐ Pressure or fullness in the ears ☐ Ear Drainage

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13. Have you had surgery on your ears? ◯ Yes ◯ No

    If *Yes*, which ear? ◯ Both ◯ Right ◯ Left

14. Do you hear noises in your ears or head? (Tinnitus) ◯ Yes ◯ No

    If *Yes*, how often do you hear these noises? ◯ Constantly ◯ Frequently ◯ Occasionally

    Which ear? ◯ Both ◯ Right ◯ Left

15. How would you describe the noise? ◯ Ringing ◯ Buzzing ◯ Roaring ◯ Screeching ◯ Crickets

16. Are you experiencing any problems with dizziness? ◯ Yes ◯ No

    If *Yes*, is your dizziness accompanied by the following? (Circle all that apply)

    ☐ Nausea ☐ Vomiting ☐ Noises in your ears ☐ Loss of Consciousness

17. Do you have any of the following? (Circle all that apply)

☐ Sinuses / Allergies	☐ Anxiety	☐ Cancer
☐ High Blood Pressure	☐ Head Injury	☐ Diabetes
☐ Kidney Problems	☐ Memory Problems	☐ Seizures
☐ Vertigo	☐ Migraines	☐ Arthritis
☐ Stroke	☐ Depression	☐ Dementia / Alzheimer's
☐ Visual Problems	Other:	

18. Do you take medications regularly? (If *Yes*, please list them below) ◯ Yes ◯ No

    ____

    ____

    18a. Do you take blood thinners? ◯ Yes ◯ No

19. Allergies to medications or plastics? ◯ Yes ◯ No

    ____

    ____

20. Have you ever been exposed to excessively loud noises? (Circle all that apply) ◯ Yes ◯ No

    ☐ Farm Equipment ☐ Hunting & Shooting ☐ Military ☐ Power Tools ☐ Music ☐ Other

21. Are there any specific questions you would like answered today?

    ____

    ____

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