CORNERSTONE AUDIOLOGY
Life is Worth Hearing

Date: _____

NAME : _____

Office Use Only:

HEARING HISTORY:	Yes	No
Is this your first hearing test?		
Have you ever had ear surgery?		
Do you have any pain in your ears?		
Do you have a history of ear infections?		
Do you have a family history of hearing loss?		
Do you have a history of noise exposure?		
Do you have noises in your ears (i.e. ringing, roaring)?		
If so, is it bothersome?		
Have you taken medication that may have affected your hearing?		
Have you noticed dizziness?		
Do you think you have a hearing loss?		
Do you have concerns with memory loss?		
Do you have issues with dexterity (fine motor skills in hands)?		

HEARING AID HISTORY:	YES	NO
Have you tried hearing aids before?		
Are you currently a hearing aid user?		
Were you satisfied with your hearing aids?		

MEDICAL HISTORY: _ Heart _ Current use of blood thinner

_ Cancer _ Diabetes _ Pace Maker _ Allergies

_ Other _____

Please feel free to use the back of the form if necessary. Thank you.

Please list situations in which you would like to hear and/or understand better:

_____ _____ _____

Do you know any patients of Cornerstone Audiology? YES NO

If yes, Who do you know?_____

Was there any specific event or circumstance that brought you in today?

_____

Is there anything else about you that we should know?

_____

_____

_____

_____