VICTORY
HEARING & BALANCE

3811 Bee Caves Road
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Patient History

Name_____ Date of Birth_____
Reason for your visit today? _____
_____

Medical / Audiological History

How is your general health? _____
Recent Hospitalization or Surgeries: _____
History of Diabetes? ☐Yes ☐No Explain: _____
History of Ear Disease? ☐Yes ☐No Explain: _____
Family History of Hearing loss? ☐ Yes ☐ No Explain: _____
Present Medications: _____
History of Trauma to the Head: ☐ Yes ☐ No Explain: _____

Do you have: ☐ Dizziness ☐ Vertigo ☐ Loss of Balance ☐ Nausea
Describe: _____
When did it begin?: _____
Duration: _____
How often it occurs?: _____
Was it accompanied by nausea and vomiting? _____

Do You Have Tinnitus? (Ringing, Buzzing, Hissing) _____
☐ Left Ear ☐ Right Ear ☐ Both Ears Since When?: _____
How Frequent?: _____ What duration? _____
Describe:_____
History of Noise Exposure? _____
Ever worn Hearing aids? _____

Hearing Difficulty Questionnaire

	Hearing Quality			*Importance to You*		
Listening Situations	Poor		Normal	Not	Somewhat	Very
Quiet (One on One conversation)	1	2	3	1	2	3
Viewing / Listening to Television	1	2	3	1	2	3
Leisure Activities	1	2	3	1	2	3
Restaurants	1	2	3	1	2	3
Church	1	2	3	1	2	3
Meetings/Groups	1	2	3	1	2	3
Work Place/ Office	1	2	3	1	2	3
Telephone/Cell Phone	1	2	3	1	2	3
In a Car	1	2	3	1	2	3
Male Voice	1	2	3	1	2	3
Female Voice	1	2	3	1	2	3
Children's Voices	1	2	3	1	2	3
Other (Indicate)_____	1	2	3	1	2	3

Patient's Signature _____ Date_____