NewGen Hearing Centers
Dr. Joseph K. Durán

CASE HISTORY

Patient Name: _____**Age:**_____ **Date:**_____

1. Chief complaint:
   - ☐ Hearing Loss, ☐ Right ear ☐ Left ear
   - ☐ Tinnitus/Ringing, ☐ Right ear ☐ Left ear
   - ☐ Dizziness
   - ☐ Difficulty understanding, ☐ in Quiet ☐ in Noise
   - ☐ Difficulty hearing/understanding on the telephone, ☐ Right ear ☐ Left ear

2. How long have you noticed this difficulty?
   - ☐ Sudden, _____# of Months, _____# of Years? _____

3. Are you experiencing ear pain?
   - ☐ Yes ☐ No, If yes - ☐ Right ear ☐ Left ear, Onset: _____

4. Do you feel one ear hears better than the other?
   - ☐ Yes ☐ No. If yes, which one is better ☐ Left ☐ Right

5. Do you currently use or have you in the past used a Hearing Aid? ☐ Yes ☐ No
   If yes, in which ear? ☐ Right ☐ Left
   How long have you used a hearing aid? _____
   What would improve your current hearing aid? _____

6. In what situation(s) do you have difficult hearing/understanding? _____
   _____

7 Is this problem due to a work-related injury or other type of accident/injury? ☐ Yes ☐ No?
   If so: date of Injury:_____
   If so: explain: _____

8. a. Did you/do you work in a noisy environment? ☐ Yes ☐ No
   If so, explain:_____

   b. Have you ever been exposed to loud noise, either recently or in the past? ☐ Yes ☐ No
   If so: type of exposure: _____

9. Have you ever had surgery/treatment for your ears? ☐ Yes ☐ No
   If so: describe: _____

10. Have you experienced a serious head injury? ☐ Yes ☐ No
    If so: describe: _____

12. Have you seen an Ear, Nose and Throat Physician? ☐ Yes ☐ No
    If so: who did you see? _____ When? _____

13. Is there a history of hearing loss in your family? ☐ Yes ☐ No
    If so: who? _____

14. Have you ever had an ear infection? ☐ Yes ☐ No

If so, ☐ as a child ☐ as an adult. Date of last infection: _____

15. Have you ever experienced dizziness, unsteadiness, imbalance or vertigo? ☐ Yes ☐ No
    If yes, do you feel dizzy today? ☐ Yes ☐ No
    If yes, please describe: _____
    Frequency of occurrence: _____
    If yes, is it accompanied by:
    ☐ nausea ☐ ringing in your ears ☐ hearing loss ☐ visual disturbances ☐ other

16. Have you fallen within the past 12 months? ☐ Yes ☐ No
    If yes, how many falls have you experienced in the last 12 months? _____
    If you have fallen, have you been injured? ☐ Yes ☐ No
    If yes, describe your injuries: _____

17. Do you have a Latex allergy? ☐ Yes ☐ No
    Do you have any other allergies? ☐ Yes ☐ No Specify: _____

18. Do you use tobacco products? ☐ Yes ☐ No

19. Do you take any prescription medications/vitamins on a regular basis? Please list:
    _____For:_____ Dosage_____ Frequency_____
    _____For:_____ Dosage_____ Frequency_____
    _____For:_____ Dosage_____ Frequency_____
    _____For:_____ Dosage_____ Frequency_____

20. Please check any of the following that you currently have or have had in the past:

__ Arthritis	__ Head Injury	__ Malaria	__ Neurological	__ Vascular
__ Asthma	__ Heart Trouble	__ Measles	__ Parkinson's	__ Visual Trouble
__ Bell's Palsy	__ Hepatitis	__ Meningitis	__ Scarlet Fever	__ Other
__ Cancer	__ High Blood Press	__ Mumps	__ Sinusitis	_____
__ Diabetes	__ HIV	__ M. Sclerosis	__ Stroke/TIA	_____

21. What questions or problems would you like help with today?
    _____
    _____

Office Use Only:
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