MICHAEL J. DAVIS, PHD

Case History Form

Date_____ **Name**_____

Address_____

City_____ State_____ Zip_____

Phone_____ Date of Birth_____

Marital Status: □ Single □ Married □ Widowed

Occupation_____ (current or retired)

Email address_____

Primary Care Physician_____

How did you hear about us? □ Relative/Friend □ Newspaper □ Mail □ TV □ Doctor □ Phonebook □ Internet □ Other_____

Observing Party Name_____ (spouse, daughter, son, friend, other)

_____

CONFIDENTIAL CASE HISTORY MEDICAL HISTORY

Have you seen a doctor specializing in diseases of the ear in the last six month? □Yes □No

If yes to question above, please give doctor's name and date seen.

_____

Have you been diagnosed with any of the following?

Otosclerosis □Yes □No Cholesteatoma □Yes □No Labyrinthitis □Yes □No

Meniere's Disease □Yes □No Barotrauma □Yes □No Permanent hearing loss □Yes □No Bell's Palsy □Yes □No Acoustic neuroma □Yes □No Ossicular dislocation/fixation □Yes □No

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

___Arthritis ___Heart Disease ___Measles ___Parkinson's Disease ___Asthma ___Hepatitis ___Meningitis ___Sinusitis ___Diabetes ___HIV ___Stroke/TIA ___High Blood Pressure ___Head Trauma ___Vision Loss ___Cancer ___Neurological Problems ___Migraines ___Seizure Disorder ___Scarlet Fever ___Temporomandibular Joint Disorder (TMJ) Have you ever had any type of EAR surgery? □Yes □No

If yes to the question above, When? _____ By Whom? _____ What type of surgery? _____

Do you take daily 80 mg Aspirin or any Blood Thinners? □Yes □No

Do you have any of these symptoms? Deformity of the ear?..... □Yes □No

Do you have any pain in your ear?.....□Yes □No

Sudden or rapid hearing loss?..... □Yes □No

Episodes of Dizziness?.....□Yes □No

Hearing loss in one ear in the last 90 days?..... □Yes □No

Have you ever seen a doctor for wax removal?..... □Yes □No

Discharge from ear in the past 90 days?..... □Yes □No

Which ear your poorer ear?..... □ Left □ Right □ Same

HEARING HISTORY Do you think you have hearing loss? □ Yes □ No

If yes, How long have you been having difficulty?

_____

Have you ever had your hearing tested? □ Yes □ No If yes, When? _____
By Whom? _____

What were the findings?

_____

Do you wear hearing aids now? □ Yes □ No If yes, when did you get them? _____

Where did you get them? _____

Were you in the Military? □ Yes □ No

If yes, were you exposed to gunfire? □ Yes □ No

If yes, What type? □ Rifle □ Artillery □Tanks

Does anyone else in your family have a hearing problem? □ Yes □ No

If yes, What is their relationship to you?

_____

Do you feel your hearing has changed? □Yes □No If yes, □ Gradual □Sudden

Do you or have you experienced any of the following?

Ear pressure/fullness?..... □Yes □No

Popping Sensation in the ear?..... □Yes □No

Ear pain?..... □Yes □No

Fluctuating hearing loss?..... □Yes □No

Swimmer's ear?..... □Yes □No

Difficulty hearing on the telephone?..... □Yes □No

Do you experience difficulty with…

Hearing in a crowd or other noisy situations where background noise is present? □Yes □No
Understanding all the words in conversation clearly? □Yes □No

Please rank the following in order of importance using 1 – 4 (1 being the most important and 4 being least important.

Example: if cosmetic appearance is the most important it should be given a number 1 and if expense is the least important then it should be given a number 4)

_____Improved hearing in quiet _____Improved hearing in noise
_____Cosmetic appearance _____Expense

Notes:_____
_____
_____
_____
_____