Berrie's Hearing & Optical Center

Serving the Midcoast Region Since 1936

Case History - Audiology

Patient Name: _____Date of Birth: _____ Today's Date:_____

What medications are you currently taking? _____

(Provide List if needed)

Do you currently use tobacco products? Yes ❑ No ❑

HEARING HISTORY

Do you have a history of:

❑ Ear Drainage ❑ Ear Infections ❑ Pain in the ears ❑ Noise Exposure

❑ Tinnitus (Ringing, Buzzing, Hissing or other noises in the ear) ❑ Dizziness

❑ Ear Surgery

Was your hearing loss? (circle one) Sudden • Progressive • Gradual • Fluctuating

Has your hearing ever been evaluated before? Yes ❑ No ❑

If yes, when? _____ Where?_____

What were the findings & recommendations? _____

LISTENING DIFFICULTIES

Please list your top three most difficult listening situations

- _____
- _____
- _____

HEARING AID HISTORY

Are you interested in learning about hearing aid options, either for the first time or as a replacement?

Yes ❑ No ❑

Have you ever worn a hearing aid? Yes ❑ No ❑

If yes, how many years have you worn hearing aids?_____

Are you currently wearing hearing aids? Right ear ❑ Left ear ❑ Both ears ❑

Where did you purchase these hearing aids?_____

Are you pleased with their performance? Yes ❑ No ❑

If no, explain any problems you have:_____

_____

_____