



BRAD T. MATHIAS, MD

Board Certified

Otolaryngology

478-452-4800

112-C Wrights Drive

Located behind First National Bank

YOUR HEARING HEALTH

PATIENT CASE HISTORY

A. ABOUT YOUR EARS

1) Do you have any of the following signs or symptoms? **PLEASE CIRCLE IF YES**

- a) Deformity of the ear
- b) Drainage for either ear **Left Right Both**
- c) Sudden or rapid loss of hearing in the last 90 days
- d) Acute or recurring dizziness
- e) Hearing loss in ONE ear in the last 90 days **Left Right**
- f) Which is your better ear **Left Right**
- g) Ever seen a doctor for wax removal **Yes No**
- h) Pain in your ears **Left Right Both**
- i) Ringing or noises in your ears **Left Right Both**
- j) What medications do you currently take? _____

2) Have you ever served in the military? **Yes No**

3) Do you have a history of repeated ear infections? **Yes No**

4) Have you ever had trauma to either/both ear(s)? If yes, please Explain:

5) Have you ever seen an Otolaryngologist (ENT) doctor? **Yes No**

If yes, give name and address: _____

6) When was the last time you had your hearing tested? _____

7) **HAVE YOU EVER HAD ANY TYPE OF EAR SURGERY?** **Yes No**

a. If yes, Date & Type of Surgery _____

B. ABOUT YOUR HEARING

1) Do you have any difficulty with any of the following? **PLEASE CIRCLE**

a) Do people often sound as if they mumble?

b) Difficulty understanding speech in crowd or in the presence of background noise.

c) Difficulty understanding on telephone?

d) Do you or have you worked in a noisy environment? If yes, please describe: _____

e) Are you exposed to noise with hobbies or other activities? If yes, please describe: _____

f) When did you first notice you had difficulty hearing or understanding speech? _____

g) Did your hearing/understanding of speech gradually decrease? **Yes No**

h) Does anyone else in your family have a hearing problem? If yes, please describe relationship and problem if known: _____

i) Do you now or have you ever worn hearing aids? **Yes No**

i. If yes, what style: _____

ii. What do/did you like about the aid(s)? _____

iii. What do/did you dislike about the aid(s)? _____

j) Do you want to improve your hearing? **Yes No**

k) In what circumstances does your hearing problem give you the most trouble? _____

l) Chief Hearing Complaint _____