# Rehder Balance & Hearing Clinic

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**Case History Review**

Patient Name: ____________________ DOB ____________ Date: ____________________

## Since your last hearing examination:

1.) Have you noticed any changes to your hearing? Yes No what changes? ____________

2.) Have you noticed any change to the ringing in your ears? Yes No N/A what changes? ____________

3.) Have you experienced the following issues?

| | Yes | No | |
|---|---|---|---|
| Ear pain/discomfort | □ | □ | Right Left Both |
| Ear infection(s) | □ | □ | Right Left Both |
| Recent drainage from ear(s) | □ | □ | Right Left Both |
| Ear Surgery | □ | □ | Right Left Both |
| Fullness or pressure in ear(s) | □ | □ | Right Left Both |
| Head injury | □ | □ | Date: ____________ |
| Perforated ear drum | □ | □ | Right Left Both |
| Ear Trauma (noise or physical) | □ | □ | What happened? ____________ |
| Dizziness or loss of balance | □ | □ | |

4.) Did you seek medical treatment for these issues? Yes No N/A What was the outcome? ____________

____________________________________________

5.) Do you have any new medical issues or diagnosis since your last hearing examination? ____________

____________________________________________

## Hearing Aid(s):

1.) Do you wear your hearing aid(s) daily? Yes No If no, why not? ____________

2.) What is the best thing about your hearing aid(s)? ____________

3.) What problems or concerns do you have with your hearing aid(s)? ____________

4.) Are you interested in discussing new updated hearing aid technology today? Yes No Maybe