UNC SCHOOL OF MEDICINE

UNC HEARING AND COMMUNICATION CENTER

6015 FARRINGTON ROAD, SUITE 103
CHAPEL HILL, NC 27517-8822

T 919.493.7980
F 919.493.7985

PATIENT HISTORY

Date:_____

Name: _____ Age: ____ DOB: _____

Employer: _____ Occupation: _____

Primary Care Physician: _____

How did you hear about our facility?_____

How long have you been aware of your hearing difficulty?_____

Did your hearing loss occur suddenly or gradually?_____

In which situations do you have difficulty hearing? (check all that apply)

_____in quiet _____in background noise _____phone _____at work

_____at school _____at lectures / worship services / theater _____television

When was your last hearing evaluation?_____

Are you in good health? YES NO If no, please explain:_____

_____

Please list your medications and the condition(s) for which you take them:_____

_____

Do you have a history of any of the following? If yes, please explain:

Ringing or noises in your ears	YES	NO	_____
Dizziness or vertigo	YES	NO	_____
Fullness / pressure in your ears	YES	NO	_____
Ear infections or ear pain	YES	NO	_____
Ruptured ear drum	YES	NO	_____
Ear surgery	YES	NO	_____
Family members with hearing loss	YES	NO	_____
Taking blood thinners / aspirin	YES	NO	_____
Head injury	YES	NO	_____
Surgery within the past year	YES	NO	_____
Excessive exposure to loud noise (military, hunting, power tools, etc.)	YES	NO	_____

_____Pneumonia _____Tuberculosis _____Diabetes _____Chemotherapy

Do you currently wear hearing aids? YES NO Make / Model:_____

If yes, are you satisfied with the aids? YES NO If no, please explain:_____

What would you like to gain from this evaluation? _____

_____