7275 Glen Forest Drive
Suite 208
Richmond, VA 23226
804-282-0022

RICHMOND Hearing Doctors
Recognized hearing experts since 1995

13925 Coalfield Commons Place
Suite 101
Midlothian, VA 23114
804-818-0000

Name: _____ DOB: _____

Thank You for choosing Richmond Hearing Doctors! Please complete the front AND back of this form. If you have a list of your current medications, we can copy that and you can skip question #15.

1. What is your **primary reason** for this appointment? _____

2. Do you feel you have any **difficulty** hearing? ☐ Yes ☐ No
   If yes, which ear? ☐ Right ☐ Left ☐ Both
   If yes, what is known or suspected **cause** of hearing difficulty? _____

3. Do you feel your hearing loss has been **Sudden** ☐ or **Gradual** ☐ ?

4. Has your hearing been **tested** before? ☐ Yes ☐ No
   If yes, when and where? _____

5. Do you have any **family members** with hearing loss or other ear-related issues? ☐ Yes ☐ No
   If yes, please describe: _____

6. Do you have **tinnitus, ringing, noises, or buzzing** in your ears? ☐ Yes ☐ No
   If yes, how long have you had tinnitus? _____
   If yes, which ear? ☐ Right ☐ Left ☐ Both
   If yes, is it: ☐ Constant ☐ Periodic – how often: _____
   If yes, describe it: ☐ Ringing ☐ Buzzing ☐ Chirping ☐ Static ☐ Pulsating
   ☐ Hissing ☐ Other: _____

7. Do you have **dizziness or vertigo**? ☐ Yes ☐ No
   If yes, describe: _____
   If yes, do you have nausea? ☐ Yes ☐ No
   If yes, have you consulted your physician or ENT for dizziness? ☐ Yes ☐ No

8. Do you have a history of **ear infections or surgeries** on your ears? ☐ Yes ☐ No
   If yes, please describe: _____

9. **In the last 90 days**, please check if you have had any of the following: ☐ None of the below

☐ **Ear pain/discomfort**	☐ Right ear	☐ Left ear	☐ Both ears
☐ **Ear drainage**	☐ Right ear	☐ Left ear	☐ Both ears
☐ **Fullness/pressure in ears**	☐ Right ear	☐ Left ear	☐ Both ears

10. Do you have a history of **noise exposure** at **ANY** time in your life? ☐ Yes ☐ No
    If yes, check all that apply: ☐ Loud concerts/music ☐ Military-related noise ☐ Firearms
    ☐ Farm equipment ☐ Power tools ☐ Industrial machinery
    ☐ Other: _____

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11. Do you currently, or have you ever, worn **hearing aids**? ☐ Yes ☐ No
    If yes, when and where did you purchase them? _____
    If yes, were you/are you satisfied? ☐ Yes ☐ No
    Comments: _____

12. Do you feel you **need** hearing aids/new hearing aids? ☐ Yes ☐ No ☐ Maybe

13. List situations in which you have difficulties hearing (if appropriate): _____
    _____

14. Which ear do you use on the phone? ☐ Right ☐ Left

    (Mark all that apply) ☐ Landline ☐ iPhone ☐ Android

15. Please check all **medical conditions** that apply: ☐ None
    ☐ Diabetes ☐ High Blood Pressure ☐ Cancer ☐ Head Trauma ☐ Serious Infection
    ☐ Stroke ☐ Vision Problems ☐ Arthritis ☐ Other: _____

16. Have you used **tobacco products** (cigarette, cigar, smokeless tobacco) one or more times in past 24 months?
    ☐ Yes ☐ No
    If yes, how often and what type? _____

17. Please provide any other information about your **general health or hearing health** that you feel may be helpful to today's appointment: _____
    _____

18. Please list current **medications** including all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary/nutritional supplements:

Medication:	Dosage:	Frequency:	Delivery Method:

_____ _____
Signature Date