

AUDIOLOGY HISTORY FORM

Patient Name: _____ DOB: _____

How did you hear of us? _____ TODAY'S DATE: _____

Do you have difficulty understanding conversations:

In a quiet room.....	Yes	No	Sometimes
At a distance.....	Yes	No	Sometimes
When someone whispers.....	Yes	No	Sometimes
On the telephone.....	Yes	No	Sometimes
In a restaurant.....	Yes	No	Sometimes
In the car.....	Yes	No	Sometimes
When several people are talking.....	Yes	No	Sometimes
With your doctor in the examination room.....	Yes	No	Sometimes
At the checkout counter in a store.....	Yes	No	Sometimes
Do others complain that you set the television too loud?.....	Yes	No	Sometimes
Do others complain that you misunderstand conversations?.....	Yes	No	Sometimes
Do you hear the turn signal in the car?.....	Yes	No	Sometimes

Do you experience:

Lightheadedness.....	Yes	No	Sometimes
Spinning sensations.....	Yes	No	Sometimes
Imbalance.....	Yes	No	Sometimes

Do you experience tinnitus (noises in your ears/head)? Yes No Sometimes
 All of the time _____ Often _____ If yes, which ear(s) _____

Do you have ear pain or a feeling of pressure? Yes No Sometimes

Do you have a history of recurrent ear infections? Yes No Sometimes
 Explain: as a child and/or currently? _____
 If yes, when was your last infection? _____

In your lifetime, have you ever been exposed to loud noises? Yes No Sometimes

Circle any of the following: Guns, Rifles, Factory Machines, Power Tools, Heavy Equipment, Trucks, Construction, Demolition, Concerts, iPod&MP3 players, Other _____

For how long were you exposed to loud noises? _____

Did/do you wear hearing protection Yes No Sometimes

Have you had any surgery on your ear(s) Yes No Sometimes
 Explain: _____

Have you experienced any head trauma that resulted in a skull fracture or concussion? Yes No
 Please explain: _____

Does anyone in your immediate family have a hearing loss or wear hearing aids? Yes No
 Who & How long? _____

Have you recently seen or are you scheduled to see an Ear, Nose & Throat doctor? Yes No
 If so, who and when? _____

**** Certain medications and health conditions are known to be associated with hearing loss.**

Circle any medications that you have taken:

Chemotherapy Drugs, “_Mycin” antibiotics, Aspirin, Quinine, Viagra, Cialis

Circle any condition that you have: High Blood Pressure, Heart Disease, Kidney Disease, Diabetes, STDs, Meniere’s Disease, Hypothyroidism, Dementia