AUDIOLOGICAL CASE HISTORY

Date: _____

Patient Name: _____ Mr. Mrs. Miss Ms. Dr. Rev.
First Last Middle Initial (circle one)

Date of Birth: _____ Age: _____ Gender: E-mail:_____

Please tell us what prompted you to come today? _____

_____

Emergency Contact: _____ Phone: _____ Relationship: _____

Hearing History

Is there a history of hearing loss in the family? □ Yes □ No
If yes, was the person hearing impaired later in life? □ Yes □ No
What is their relationship to you? _____

Do you have a history of □ Ear Drainage □ Dizziness □ Ear Infections □ Earaches/ Pain
□ Meniere's Disease □ Head Trauma □ Excessive Wax

When did you first notice hearing difficulty? _____

Is the hearing problem (circle one): □ sudden onset □ fluctuating □ stable or □ getting worse?

Is your hearing better in one ear? □ Yes □ No If yes, which ear is the better ear? □ Right □ Left

Has your hearing ever been evaluated before? □ Yes □ No

If yes, when? _____ Where? _____

Does your hearing problem interfere with: □ Work? □ School? □ Family? □ Social life? □ Intimacy?

Do you struggle to hear: □ Phone? □ TV? □ Webcast? □ Drive-thru? □ Conversation in the car?

Tinnitus History (Ringing in the ears)

Do you experience tinnitus? □ Yes □ No If yes: □ Left □ Right □ Both □ Intermittent □ Constant

On a scale of 1 (barely notice) to 10 (suicidal thoughts): How bad is your tinnitus? _____

Does tinnitus prevent you from sleeping or enjoying life? □ Yes □ No _____

Hearing Aid History

Have you ever worn a hearing aid? □ Yes □ No If no, proceed to **Noise History** section

If yes, how many years have you worn hearing aids? _____

Are you currently wearing hearing aids? □ Both ears □ Right ear □ Left ear

What kind are they? _____ How long have you had them? _____

Do you feel you get benefit from your hearing aids? □ Yes □ No

If no, tell us what you didn't like about them: _____

_____

Communication

Which of the following do you use? □ A Smart Phone: Make and model _____

□ Landline or Work Phone □ Cell Phone □ Blue Tooth Enabled Car □ Computer or Tablet

Noise History

Have you ever been in the armed services? □ Yes □ No How long? _____ Which branch? _____

Please check the loud places and/or loud sounds you have experienced commonly.

□ Jet Engines □ Rock Music □ Earphones Cranked Loud
□ Power Tools □ Band □ Firearms
□ Hunting □ Workplace Noise (Dentist Office, Beauty Salon, Factory, Farm, Construction)

Are you bothered by loud sounds? □ Yes □ No

Medical History

Primary care physician: _____ City:_____ Phone:_____

Please check any significant health problems you have experienced:

□ Stroke □ Cancer □ HIV □ Heart Attack □ Headaches □ Seizures □ Dizziness □ PTSD
□ Type 1 Diabetes □ Type 2 Diabetes □ Measles □ Sleeping Problems □ Depression □ Suicidal Thoughts
□ Bell's Palsy □ Sinusitis □ High Blood Pressure □ Erectile Dysfunction □ Fatigue □ Anxiety □ Memory Loss
□ Parkinson's □ Kidney Problems □ Hepatitis □ Other: _____

Are you wearing Pacemaker? □ Yes □ No

Have you been hospitalized recently? □ Yes □ No Have you had surgery on your ears? □ Yes □ No

Which prescribed medications are you taking? Which over-the-counter medications or vitamin supplements?

_____

Do you regularly take Aleve, Tylenol, Aspirin, or Advil? □ Yes □ No _____