Acct#_____

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? _____

<u>In your lifetime</u>, 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**
Does anyone in your immediate family have a hearing loss or wear hearing aids?	**Yes**	**No**
Have you recently seen or are you scheduled to see an Ear, Nose & Throat doctor?	**Yes**	**No**

Please explain:_____

Who & How long? _____

If so, who and when? _____

**** <u>Certain medications and health conditions are known to be associated with hearing loss.</u>**

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