Adult History

Name: _____ **Age** _____

Reason for today's visit?

Audiology/Medical History

How is your general health?

_____

History of ear disease? Yes No

If yes, explain _____

Family history of hearing loss? Yes No

If yes, explain _____

History of hearing loss? Yes No

History of noise exposure? Yes No

If yes, explain _____

Have you ever worn a hearing aid? Yes No

Are you currently employed? Yes No

If yes, occupation? _____

Do you have dizziness, vertigo or loss of balance? Yes No

If yes, explain _____

Do you have any tinnitus? Yes No If yes, which ear? Right Left Both Since when? _____
(i.e. ringing, buzzing, hissing) How frequent? _____ What is the duration? _____

Recent hospitalizations/surgeries Yes No

If yes, explain _____

History of Diabetes? Yes No

Do you currently smoke or use any other form of tobacco? Yes No

Do you wear a pacemaker? Yes No

Please circle any that apply:

Arthritis	Recurrent Headaches	Measles	Stroke
Cancer (Type_____)	Constant Headaches	Meningitis	Typhoid Fever
Chemotherapy	Head Injury	Migraines	Vascular problems
Shingles	Heart problems	Mumps	Under aspirin regimen
Encephalitis	High Blood Pressure	Neurofibromatosis	Eye problems
Fatigue	Malaria	Scarlet Fever	Neurological symptoms

Allergic to the following: _____

	Yes	No
Do you agree to receive quarterly educational email/mail updates?	☐	☐
Are you on Facebook?	☐	☐

Hearing Difficulty Questionnaire

Listening Situations	Hearing Quality (See Key Below)	Importance to You		
		Not	Somewhat	Very
Quiet (one to one conversations	1 2 3 4 5	1	2	3
Television	1 2 3 4 5	1	2	3
Leisure Activities	1 2 3 4 5	1	2	3
Restaurants	1 2 3 4 5	1	2	3
Church/Synagogue	1 2 3 4 5	1	2	3
Meetings/Groups	1 2 3 4 5	1	2	3
Work Place	1 2 3 4 5	1	2	3
Telephone	1 2 3 4 5	1	2	3
Car	1 2 3 4 5	1	2	3
Male Voice	1 2 3 4 5	1	2	3
Female Voice	1 2 3 4 5	1	2	3
Child's Voice	1 2 3 4 5	1	2	3
Other(please indicate)	1 2 3 4 5	1	2	3

_____

_____ _____

Patient's Signature Date

1. Always
2. Almost Always
3. Most of the Time
4. Once in a While
5. Hardly ever

Name: _____

List of Current Medications

Name of Medication	Dosage	How/How Often Taken	Reason	Date Started	Prescriber