Hearing & Balance Center, P.C.
Audiologic Case History

Date: _________________________

Name:_________________________________ Age:________________________

Reason for Hearing Evaluation (Check all that apply)

___Difficulty Hearing: ___Right ear ___Left ear ___Both are the same

___Balance Problems Explain:____

___Ringing in ears/head ___Right ear ____Left ear ___Both ears

Duration of symptoms: ___Constant ___Fluctuating ___________Date of Onset

Situations where difficulty is especially apparent:___________________________

Which ear do you use for the telephone? ____ ____ Why?(habit, clarity,etc.)________________

What noise exposure have you had in your lifetime?___________________________________

Explain:____

____

Did you wear ear protection when in noisy situations? ____ Consistently?__________________

Is there a family history of hearing and/or balance problems?_____________________________

Explain:____

Have you ever worn hearing aids? _____ Which ear, and number of years worn? ___________

____

Where would you like today's report of the hearing evaluation to be sent?

____

____

Are you being treated for depression?_______ Do you feel depressed?_________

Please have list of your current medications available.