Adult Hearing History

Date__________________

Name____DOB_____________Age_________

Address____Sex__________

City____State__________Zip__________

Telephone: Work___________________Home________________SS#__________________________

Current Occupation_________________________________ Referred by________________________

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☐ Yes ☐ No Do you have a hearing problem? If yes, is it: ☐ Mild ☐ Moderate ☐ Severe

For how long have you had the loss?______Did the loss occur: ☐ Gradually ☐ Suddenly ☐ Fluctuating

Is the loss in the: ☐ Right ☐ Left ☐ Both Which ear is better? ☐ Right ☐ Left ☐ Unsure

Do you have trouble hearing in any of the following situations:

Telephone	☐ Yes	☐ No	Men talking	☐ Yes	☐ No
At social gatherings	☐ Yes	☐ No	One on One talking	☐ Yes	☐ No
Background noise	☐ Yes	☐ No	Women talking	☐ Yes	☐ No
Television	☐ Yes	☐ No	Other (please list)________________________		

☐ Yes ☐ No Are you currently taking any prescription or nonprescription drugs? For what?

Please list____

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Present Symptoms:

☐ Yes ☐ No Do you have: Noises in your ears? If yes: ☐ Right ☐ Left ☐ Constant ☐ Periodic

☐ Yes ☐ No Ear pain? ☐ Right ☐ Left

☐ Yes ☐ No Ear drainage? ☐ Right ☐ Left

☐ Yes ☐ No Infection? ☐ Right ☐ Left

☐ Yes ☐ No Do you currently have ☐ nausea ☐ headaches ☐ dizziness?

☐ Yes ☐ No Have you fallen in the last year? List how many times and when________________

☐ Yes ☐ No Are you currently being treated by a doctor for ear problems? Explain___________
Circle all that apply.

Exposure to excessive noise levels without hearing protection: Job, Military, Recreation (i.e., firearms, music, motorcycles), Other_________________________________

Do you have:	Diabetes	Hypoglycemia (low blood sugar)	Vertigo (spinning)
	Imbalance	Other dizziness	High blood pressure
	Low blood pressure	History of migraines	Heart disease
	Kidney disease	Ear surgery ☐ Right ☐ Left	High fever
	Stroke	Serious head trauma	Falling

To your knowledge, have you ever received: intravenous antibiotics Chemotherapy

High dose Vicodin High dose Aspirin Quinine

☐ Yes ☐ No Do you have any family members with hearing loss? Who?___________________

When did the family members lose hearing? ☐ Birth ☐ Mid-life ☐ Late-onset

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☐ Yes ☐ No Do you now, or have you ever worn a hearing aid?

If yes, ☐ Right ☐ Left ☐ Both Make______________Model_____________________________

Is it satisfactory? ☐ Yes ☐ No If not, why?____

What do you expect to gain from your visit to the Audiology clinic?____________________________

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Comments/Observations____

Clinician:_____

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