Audiologic History

Name: _____ Birthdate: _____

Describe your chief complaint or reason for referral: _____

Have you had your hearing evaluated previously? □ Yes □ No If so, where the results?_____

Do you have hearing loss? □ Yes □ No If so, which ear? □Right □Left □Both

When did it begin? _____ Has it become worse? □ Yes □No

What caused hearing loss? _____

Is there a family history of hearing loss? □Yes □ No If so, who had hearing loss? _____

What was the age it began? _____What caused the hearing loss? _____

Describe the situation where you have a hard time understanding speech:_____

_____

Have you had a history of loud noise exposure? □ Yes □ No

Where were you exposed? □ Work □ Military □ Hobbies (woodworking, shooting, motocycles, etc)

How long were you exposed?_____ Did you use ear protection? □ Yes □ No

Do you hear noise, ringing, or buzzing in the ears? □ Yes □ No If so, in which ear? □Right □Left □Both

Describe how it sounds _____

Have you had dizziness or vertigo? □ Yes □ No If so, was it treated by a physician? □ Yes □ No

If so, describe you symptoms_____

Have you had surgery on your ears? □ Yes □ No If so, which ear? □Right □Left □Both

What type of surgery did you have? _____When and where was your surgery? _____

Have you had an ear injury? □ Yes □ No If so, describe _____

Have you had ear infections in the past? □ Yes □ No If so, what ear? □Right □Left □Both

When was the last ear infection?_____

Do you currently have drainage in your ears? □ Yes □ No If so, what ear? □Right □Left □Both

Have you had a head injury? □ Yes □ No If so, describe_____

Have you been exposed to radiation (cancer treatment)? □ Yes □ No

Do you have diabetes? □ Yes □ No If so, what kind_____

Do you take blood thinners (Coumadin, Warfarin, Aspirin, etc) □ Yes □ No

List any current medications: _____

_____

Which ear do you normally use for the phone? □ Right □ Left

Have you used a hearing aid previously? □ Yes □ No If so, which ear? □Right □Left □Both

What type of aid? _____ How long did you use it? _____

How did it benefit you? _____

_____ _____ _____

Signature of person completing questionnaire **Relationship to Client** **Date**