



## CONFIDENTIAL AUDIOLOGY CASE HISTORY FORM

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

1. Have you experienced any of the following conditions? If YES, briefly explain.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Chronic Ear Infections  | <input type="checkbox"/> Deformity of the ears   | <input type="checkbox"/> One-sided Hearing Loss | <input type="checkbox"/> Sound Sensitivity |
| <input type="checkbox"/> Meniere's Disease       | <input type="checkbox"/> Visual Problems         | <input type="checkbox"/> Sinus Problems         | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Heart Condition         | <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Head Trauma       |
| <input type="checkbox"/> Cancer/Cancer Treatment | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Genetic Disorders      | <input type="checkbox"/> Liver Disease     |
| <input type="checkbox"/> Anemia/Blood Disorders  | <input type="checkbox"/> Nervousness/Anxiety     | <input type="checkbox"/> Depression             | <input type="checkbox"/> Dizziness         |
| <input type="checkbox"/> Alzheimer's/Dementia    | <input type="checkbox"/> Allergies (List): _____ |   |  |

Comments: \_\_\_\_\_

2. Are you currently a smoker?  Yes  No If yes, how many years? \_\_\_\_\_

3. Have you fallen at all in the last 24 months?  Yes  No If yes, how many times? \_\_\_\_\_

4. Do you think you have a hearing problem?  Yes  No

If yes, how long have you noticed the problem: \_\_\_\_\_

Was the onset:  Sudden  Gradual

Which ear is poorer:  Left  Right  Unsure

Does your hearing remain:  Constant  Fluctuate

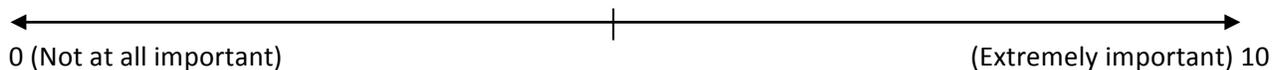
Has your hearing become worse since you first noticed the problem:  Yes  No  Unsure

5. Do you currently have **difficulty** hearing or understanding any of the following?

- |                                      |  |   |  |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> Watching TV | <input type="checkbox"/> Using the telephone | <input type="checkbox"/> One on one conversations | <input type="checkbox"/> Doorbell/knocking |
| <input type="checkbox"/> Restaurants | <input type="checkbox"/> At the movies       | <input type="checkbox"/> Worship Service          | <input type="checkbox"/> Telephone ring    |
| <input type="checkbox"/> Crowds      | <input type="checkbox"/> Fire/smoke detector | <input type="checkbox"/> Sirens                   | <input type="checkbox"/> Alarm clock       |

Other (List): \_\_\_\_\_

6. How important is it for you to improve how you hear, understand, or communicate with others **RIGHT NOW**:  
(mark on the line)



7. Have you had your hearing tested before?  Yes  No If yes, when and where: \_\_\_\_\_

8. Have you had any drainage from the ear within the past 90 days?  Yes  No

9. Have you experienced any dizziness, balance problems, or falls?  Yes  No

10. Have you had any pain/discomfort in your ears with the past 90 days:  Yes  No

(TURN OVER)

11. Do you have any noises or ringing in your ears? Yes No Left ear/ Right ear/ Both  
If present, is it: Constant Intermittent When did you first notice it? \_\_\_\_\_

12. Have you been exposed to loud noises? (Employment, Military, Recreation, etc.) Yes No  
If yes, describe the type of noise: \_\_\_\_\_

13. Have you seen or had ear surgery by an ENT? Yes No  
If yes, please explain: \_\_\_\_\_

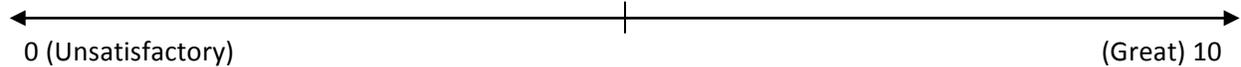
14. Have you seen your primary doctor in the past 6 months? Yes No  
If yes, who: \_\_\_\_\_

15. Have you ever seen a doctor for wax removal? Yes No When: \_\_\_\_\_

16. Does anyone in your family have hearing loss? (ex: parents, siblings, etc.) Yes No

17. Have you recently had or done any of the following?  
Cough/Cold/Flu Flying/skydiving/Scuba diving Head Trauma  
Chiropractic adjustments of the neck Personal trauma/extreme stress

18. Have you ever worn hearing instruments? Yes No  
If yes, how would you rate your experience with your hearing aids?



19. Select all that apply:
- I have been thinking that I might need hearing aids.
  - I have started to seek information about hearing aids.
  - I am ready to wear hearing aids if they are recommended.
  - I am comfortable with the idea of wearing hearing aids.
  - I currently wear hearing aids.

Comments or questions for the audiologist: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have reviewed the above information to be true and accurate. All information obtained will remain completely confidential.

Signature \_\_\_\_\_