NORTH SIDE
AUDIOLOGY GROUP, INC.

AUDIOLOGY HISTORY

Welcome to North Side Audiology! We would like to thank you for making an appointment with our professional audiologists. Our staff is here to meet your individual hearing needs.

PATIENT NAME _____ DATE _____

WHAT DIFFICULTIES ARE YOU HAVING WITH YOUR EARS AND/OR HEARING? (CIRCLE)

PAIN FULLNESS/PRESSURE EAR INFECTIONS DIZZINESS

SUDDEN HEARING LOSS GRADUAL HEARING LOSS RINGING IN THE EARS

PLEASE EXPLAIN ALL CIRCLED _____

_____

_____

DO YOU HAVE ANY RELATIVES WITH HEARING LOSS? YES NO

HAVE YOU BEEN EXPOSED TO HIGH LEVELS OF NOISE? YES NO

IF YES, PLEASE DESCRIBE _____

HAVE YOU HAD SURGERY IN ONE OR BOTH EARS? YES NO

IF YES, PLEASE DESCRIBE _____

_____

HAVE YOU BEEN TREATED WITH CHEMOTHERAPY? YES NO

HAVE YOU SEEN A PHYSICIAN ABOUT YOUR EARS IN THE PAST 6 MONTHS? YES NO

IF YES, PLEASE EXPLAIN _____

_____

IS THIS YOUR FIRST HEARING EVALUATION? YES NO

IF YOU HAD A HEARING EVALUATION, WHEN WAS IS AND WHAT WERE THE RESULTS?

_____

IF YOU ARE HAVING HEARING DIFFICULTIES, PLEASE CIRCLE ALL THAT APPLY.

NOISY SITUATIONS QUIET SITUATIONS GROUPS CAR

PHONE MUSIC LARGE ROOMS

DO YOU CURRENTLY WEAR HEARING AIDS? YES NO

IF YOU DO, WHAT BRAND AND MODEL? _____

IF YOU COULD IMPROVE YOUR CURRENT HEARING AID(S) PERFOMANCE, WHAT WOULD YOU CHANGE?

_____