FAIRBANKS HEARING & BALANCE CENTER

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ADULT AUDIOLOGICAL CASE HISTORY

Patient's Name: ______________________________ DOB: _____/_____/________ Date: ______________________

Referral Source:______________________

HEARING HISTORY:

What is your primary reason for coming in today?____

Do you suspect you have a hearing loss? ☐YES ☐NO

How long have you noticed this problem? _______________ Was the onset ☐ gradual or ☐ sudden?

In which ear do you hear the best? ☐ Left ☐ Right ☐ Same in both ears

Have you been exposed to recreational or occupational noise? ☐YES ☐NO

Do you use hearing protection? ☐YES ☐NO

Does anyone in your family have hearing loss? ☐ YES ☐ NO If so, Who? __________________________

Have you ever had your hearing tested? ☐YES ☐NO If yes, when and where? ________________________

What were the results? ____

Have you ever worn a hearing aid? ☐ YES ☐ NO Do you currently? ☐ YES ☐ NO

If so, in which ear? ☐ Left ☐Right Do you wear the aid(s) regularly? ☐YES ☐ NO

Do you benefit from the hearing aid(s)? ☐YES ☐NO

MEDICAL HISTORY:

Have you had earaches or drainage from your ears within the last 90 days?☐YES ☐NO

Have you ever had medical/surgical treatment for your ears? ☐ YES ☐ NO

If yes, what age? ____

Do you ever have dizziness, balance problems, or falls? ☐ YES ☐ NO

Have you ever been evaluated for your dizziness? ☐YES ☐NO

If yes: Where? ____

Do you notice any tinnitus (for example: ringing, buzzing, or roaring) in your ears? ☐YES ☐NO

If yes, which ear? ☐ Right ☐ Left ☐ Both Is it bothersome: ☐ YES ☐ NO

Is there any other information related to your hearing you feel might be important for the Audiologist to know? ____________

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