COMPREHENSIVE
AUDIOLOGY
ESTHER FOGEL, AuD

Audiology History – Adult

Name_____ Date of Birth_____ __M __F

Today's Date_____

Primary Care Physician_____

Phone Number of Primary Care Physician_____

Address of Primary Care Physician_____

Emergency Contact _____Phone #_____ Relationship_____

Referred by_____ Reason_____

Occupation_____ Hobbies_____

HEARING

What is your primary reason for today's visit?_____

Do you think you have hearing loss? __Yes __No

If yes, for how long have you been aware of your hearing loss?_____

Was your hearing loss sudden or gradual?_____

Do you hear better from one ear compared to the other? __Yes __No

If yes, which is the better ear? __Right __Left

Which ear is worse? ___Right ___Left

Do you have a family history of hearing loss? __Yes __No

Do you have a history of noise exposure? __Yes __No

If yes, please describe. Work, military, or recreational?_____

Have you ever been evaluated by an audiologist or ENT? ___Yes ___No

If yes ,please explain_____

Name of doctor_____ Date of evaluation_____

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In which situations do you have difficulty hearing? Please check all that apply.

___When speaking with one individual person
___ In a small group (small dinner party, playing cards)
___ In a large group (meetings, conferences, church or synagogue)
___ On the telephone
___ In a noisy environment (parties, restaurants)
___ Communicating with colleagues, clients, or employees at work
___ In the car
___Other (Please explain)_____

MEDICAL HISTORY

Do you have a history of any of the following? Please check all that apply:

____Ear infections
____Ear, Nose, or Throat surgery Please describe_____
____Ear Pain or Discomfort
____Ear Drainage
____Ear Fullness / Pressure
____Tinnitus (ringing /noises in your ears or head)
____Dizziness or Vertigo

Do you have a history of any of the following medical conditions (Please check all that apply)

____Heart condition
____Pacemaker
____Diabetes
____Kidney disease
____Vision loss
____High blood pressure
____Head trauma or Injury
____Migraines
____Peripheral Neuropathy
____Tingling or numbness in your hands
____Tingling or numbness in your face
____Measles or Mumps
____Meningitis
____CMV
____Sinusitis
____Meniere's Disease
____Multiple sclerosis
____HIV or AIDS
____Hepatitis
____Bell's Palsy
____Parkinson's Disease
____Stroke /TIA
____Neurological Disorders
____MRI or CT of the head
____Anxiety/Depression
____Arthritis
____Liver disease
____Thyroid disease
____Allergies/Asthma
____Other:_____
_____

Please list your current **medications**:

Medication _____ Reason_____
Medication _____ Reason_____
Medication _____ Reason_____
Medication _____ Reason_____

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Please list any **allergies** to medications or foods_____

Are you allergic to latex gloves? __Yes __No

Please list any previous **surgeries** or **hospitalizations**_____

_____

SOCIAL INFORMATION

Tobacco Use: Do you smoke? ____Yes ____No

Alcohol Use: Do you drink alcohol? _____ How many drinks per week? _____

Do you exercise? _____ How often?_____

Do you consume caffeinated products? _____

Have you recently noticed an increase in sadness or gloominess? _____Yes _____No

Have you lost interest in enjoyable activities? _____Yes _____No

HEARING AIDS

Do you currently wear hearing aids? ____Yes _____No

Please rank these factors in order of importance (1 being most important, 4 being least important):

___Hearing in Quiet ___Hearing in Noise ___Hearing Aid Expense ____Cosmetics

If today's test results show that hearing aids would be beneficial, how ready are you to try amplification. Please rate your readiness on a scale of 1-10:

Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready

For current hearing aid users only:

Do you wear one hearing aid or two? _____
How long have you worn hearing aids? _____
Make and model of your current hearing aids_____
How old are your current hearing aids?_____
How often do you wear your hearing aids?_____
What would you like to improve about your current hearing aids? _____

_____