AUDIOLOGICAL CASE HISTORY

NAME: _____ DATE: _____ REFERRED BY: _____

MEDICAL HISTORY:

Have you been examined by a doctor in the past six months? yes / no
If so, when/why/where? _____
Have you ever been examined by an ear, nose, and throat doctor? yes / no
If so, when/why/where? _____
Do you have ringing or other noises in your ears? no / yes right / left / both constant / occasional
Describe noise _____ Does it bother you? no / yes
Have you had ear surgery? yes / no
If so, when/why/where? _____
Acute or recurring dizziness? yes / no
Have you ever had ear infections? yes / no
How many? _____ Most recent was _____ Treated by _____
Are you on any type of medications? yes /no
List medication _____
Have you had any type of chemotherapy or drugs toxic to ears? yes / no
Do any of your family members have a hearing loss? no / yes who? _____
Have you experienced any head trauma? yes / no

HEARING HISTORY:

Have you had a recent hearing evaluation? If yes, where were you tested? _____
What were the results: _____
Has your hearing changed noticeably? no / yes gradual or sudden?
Do you hear better from one ear? If so, which one? right / left / same
Do you sometimes hear words but don't always understand them? yes / no
Do you find it difficult to hear in noise or groups? yes / no
Do you need to turn up the TV? yes / no
Do you have difficulty using the telephone? yes / no
Any exposure to loud noise (occupational or recreational)? yes / no
If yes, be specific _____

FOR HEARING AID USERS ONLY:

DO YOU HAVE ANY CONCERNS AT YOUR VISIT TODAY?
yes / no WHICH EAR: right ear / left ear / both
Please explain concern: _____
_____
_____
_____
_____

For Office Use Only:
Otologic Exam: Clear _____Rt/Lt Occluded _____Rt/Lt TM _____Rt/Lt Other _____
Notes _____
_____

03/19