HOW DID YOU HEAR ABOUT US?

Patient Name: ______________________________________

Television ☐ Doctor Referral ☐ Website/Online Search ☐

Phone Book ☐ Radio ☐ Newspaper ☐ Mailer ☐

Community Outreach ☐ Facebook ☐ Other ☐

Adult Audiological Case History

Name: ______________________ **DOB:** __________ **Today's Date:** __________

HEARING

What brought you here today? ______________________

Do you suspect you have a hearing loss? Yes No

If yes, how long have you noticed the loss? ______________________

Does it affect both ears, or just one? ______________________

Did it occur (circle one): Gradually Suddenly

Have you been exposed to any occupational or recreational noise? Yes No

If yes, please describe: ______________________

Do you have any ringing or buzzing (tinnitus) in your ears? Yes No

If yes, in which ears does it occur? ______________________

How long have you noticed the tinnitus? ______________________

Does anyone in your family have hearing loss? Yes No

If yes, please describe: ______________________

Have you ever had your hearing tested? Yes No

If yes, when and where? ______________________

Do you have any difficulty hearing / understanding in any of the following activities? (circle all that apply)

Watching TV	Worship Services	Meetings
Telephone	Restaurants	Movies

List 3 areas where you have the most difficulty hearing or understanding:

1. ______________________
2. ______________________
3. ______________________

Using the scale provided below: how important is it for you to hear better?

(1 = not important, 10 = very important)

1 2 3 4 5 6 7 8 9 10

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Using the scale provided below: how comfortable are you in making a change to improve your hearing? (1 = not comfortable, 10 = very comfortable)

Have you ever worn a hearing aid? Yes No

Do you use a hearing aid now? Yes No

If yes, for how long?____

On which ear(s) do you use the aid? Right Left

Do you wear it regularly? Yes No

Do you perceive a benefit while wearing it? Yes No

Where did you get your hearing aid from?________________________________

DIZZINESS

Do you experience any dizziness? Yes No

If yes, when did it start?____

How often does it occur?____

How long does it last?____

How else would you describe your dizziness? (circle as many as apply)

Lightheaded Disoriented Vertigo

Unsteady Nausea Difficulty walking a straight line

Pressure in the head

Is there any family history of dizziness? Yes No

If yes, please explain:____

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