PATIENT
LABEL

Audiological History

Please complete the front and back of this form so that the Audiologist you are seeing will have some background information to help provide a comprehensive assessment.

Primary concern:

____
____
____

Do you have hearing loss in: Both ears? ☐ One ear? ☐

About how long have you had a hearing problem? ____________________________________

Did your hearing loss begin suddenly? ☐ gradually? ☐

Please circle "N" no or "Y" yes for questions below. If yes, please explain in the space provided.

Y	N	Do you have tinnitus? (Ringing or other noises in ears or head)
Y	N	Do you have vertigo or balance problems?
Y	N	Do you have a history of ear infections? If so, when was your last infection?
Y	N	Have you ever had surgery on your ears?
Y	N	Have you been exposed to loud noise at **any** time in your life? (Work related, military service, recreation, loud music)
Y	N	Have you ever had a head or neck injury?
Y	N	Does your hearing fluctuate?
Y	N	Do you have a family history of hearing loss (before age 50 years of age)?
Y	N	Do you have pain or fullness in your ears? Please describe:

(Cont. on reverse)

Medical History

Major Illnesses: ☐ High blood pressure ☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Other (please list)
____
____
____

Medications/drugs that you are currently taking:____
____
____
____
____
____
____

Hearing Aid History:

Do you currently wear hearing aids? **Yes** ☐ **No** ☐

If no, have you ever worn hearing aids? **Yes** ☐ **No**☐

Social History:

Occupation____

Frequent activities that involve communicating with others?
____
____
____
____
____

Who are the most important people with whom you communicate regularly (either in person or on the telephone)**?**
____
____
____
____
____