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.

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