ADULT EAR and HEARING CASE HISTORY

Patient Name:_____ Age:_____

What concerns are you here for today?

_____ Hearing Loss _____ Ear Noises _____ Dizziness _____ Other

If other, please specify here:_____

On a scale of 1 to 10, one being bad and ten being great, how would you rate your hearing ability? (circle) 1 2 3 4 5 6 7 8 9 10

1. Have you been diagnosed with a hearing loss in the past?

_____ Yes _____ No

A. Which ear has a hearing loss? _____Right _____Left _____Both

B. How long have you known of the hearing loss?_____

C. Have you ever worn hearing aids? _____Yes _____No

D. How long have you worn hearing aids? _____

E. Do you wear one or two hearing aids? _____One _____Two

2. Does one ear hear better than the other?

_____ Right _____Left _____Neither

3. Did your hearing loss come on: _____ gradually? _____ suddenly?

4. Does anyone in your family have a hearing loss? _____ Yes _____ No

Who?_____

5. Have you ever had ear surgery? _____ Yes _____ No

A. What for and when?_____

6. Do you experience ringing/noises in the ears (tinnitus) on a regular basis?

_____ Right _____ Left _____Both

A. How long have you experienced the ringing?_____

B. How long does the ringing last when it appears?_____

C. Have you discussed this with your physician?_____

7. Do you experience ear pain or ear drainage? _____ Yes _____ No

8. Do you have concerns with ear wax build-up? _____ Yes _____ No

9. Do you experience dizziness on a regular basis? _____ Yes _____ No

   A. How often does the dizziness appear?_____
   B. How long does the dizziness last when it appears?_____
   C. Have you discussed this with your physician?_____
   D. Do you take medication to help the dizziness?_____

10. Have you been exposed to loud noises for prolonged periods of time or repeatedly?(examples include: firearms, farm machinery, lawn mowers, vacuums, factory work, construction tools, or woodworking tools)

   _____ Yes _____ No

   If **yes**, Do/Did you wear hearing protection? _____ Yes _____ No
   If **yes**, what percentage of time do/did you wear the hearing protection?

   _____ 1-25% _____ 26–50% _____ 51-75% _____ 76-100%

11. Do you experience allergies? _____ Yes _____ No

   A. Do you take daily allergy medication? _____ Yes _____ No
   B. How are your sinuses today?

   _____ Clear _____ Mostly Clear _____ Mostly Congested _____ Congested

12. Have you had or do you have the following?:
   Diabetes:_____ High or Low Blood Pressure:_____
   Memory Loss:_____ Stroke:_____
   Heart Attack with a pacemaker:_____

Please list medications here:_____

_____

_____

Who referred you to Advanced Audiology, LLC?_____

By signing below you verify the above information is accurate and you authorize Advanced Audiology, LLC to perform testing, care and management services relating to your hearing health care needs.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date