COMPREHENSIVE
AUDIOLOGY
ESTHER FOGEL, AuD

Audiology History – Adult

Name_____ Date of Birth_____ Today's Date_____

Please complete the following questions, as it will help us determine the most appropriate and personalized hearing care for you, based on your medical, hearing, and social history.
Thank you for your time!

HEARING

What is your primary reason for today's visit? _____

Do you think you have hearing loss? __Yes __No

If yes, **for how long** have you been aware of your hearing loss? _____

Was your hearing loss **sudden or gradual**? _____

Do you hear better from one ear compared to the other? __Yes __No

If yes, which is the better ear? __Right __Left

Which ear is worse? ___Right ___Left

Do you have a **family history of hearing loss**? __Yes __No

Do you have a history of **noise exposure**? __Yes __No

If yes, please describe. Work, military, or recreational? _____

Have you ever been evaluated by an audiologist or ENT? ___Yes ___No

If yes, please explain_____

Name of doctor_____ Date of evaluation_____

Please list two situations in which you would like to improve your hearing:

1._____

2._____

In which situations do you have **difficulty hearing**? Please check all that apply.

___When speaking with one individual person
___ In a small group (small dinner party, playing cards)
___ In a large group (meetings, conferences, church or synagogue)
___ On the telephone
___ In a noisy environment (parties, restaurants)
___ Communicating with colleagues, clients, or employees at work
___ In the car
___ TV (Do you use captions?) _____
___Other (Please explain) _____

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MEDICAL HISTORY

Do you have a history of any of the following? Please check all that apply:

____Ear infections
____Ear, Nose, or Throat surgery Please describe_____
____Ear Pain or Discomfort
____Ear Drainage
____Ear Fullness / Pressure
____Tinnitus (ringing /noises in your ears or head)
____Dizziness or Vertigo
____Excessive Ear Wax

Do you have a history of any of the following medical conditions (Please check all that apply)

____Heart condition
____Pacemaker
____Diabetes
____Kidney disease
____Vision loss
____High blood pressure
____High cholesterol
____Head trauma or Injury
____Migraines
____Peripheral Neuropathy
____Tingling or numbness in your hands or fingers
____Numbness on your face
____Measles or Mumps
____Meningitis
____CMV
____Sinusitis
____Meniere's Disease
____Multiple sclerosis
____HIV or AIDS
____Hepatitis
____Bell's Palsy
____Parkinson's Disease
____Stroke /TIA
____Dementia
____Neurological Disorders
____MRI or CT of the head
____Anxiety/Depression
____Arthritis
____Liver disease
____Thyroid disease
____Allergies/Asthma
____Osteoporosis
____Cancer
____Chemotherapy
____Other: _____

Please list your current **medications** (or provide a copy of your medication list):

Medication _____ Reason_____
Medication _____ Reason_____
Medication _____ Reason_____

ALLERGIES

Please list any **allergies** to medications or foods_____

Are you allergic to latex gloves? __Yes __No

SURGICAL HISTORY

Please list any previous **surgeries** or **hospitalizations**? _____

_____

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SOCIAL INFORMATION

Occupation_____ Hobbies_____

Tobacco Use: Do you smoke? ____Yes ____No

Alcohol Use: Do you drink alcohol? _____ How many drinks per week? _____

Do you exercise? _____ How often? _____

Do you consume caffeinated products? _____

Have you recently noticed an increase in sadness or gloominess? _____Yes _____No

Have you lost interest in enjoyable activities? _____Yes _____No

HEARING AIDS

Do you currently wear hearing aids? ____Yes _____No

Please rank these factors in order of importance (1 being most important, 4 being least important):

___Hearing in Quiet ___Hearing in Noise ___Hearing Aid Expense ____Cosmetics

If today's test results show that hearing aids would be beneficial, how ready are you to try amplification. Please rate your readiness on a scale of 1-10:

Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready

For current hearing aid users only:

Do you wear one hearing aid or two? _____
How long have you worn hearing aids? _____
Make and model of your current hearing aids_____
How old are your current hearing aids? _____
How often do you wear your hearing aids? _____
What would you like to improve about your current hearing aids? _____