HEAR CLEARLY

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Adult Audiological History Form

Name_____Date_____

Occupation:_____

HEARING LOSS HISTORY

Briefly State Chief complaint_____

_____

Date of onset _____ Was onset sudden or gradual? (circle one)

Please explain: _____

_____

Do you have a better ear? _____

Does your hearing fluctuate? _____

Do you have difficulty hearing?

_____ Conversation	_____ In Quiet Settings	_____ Television
_____ Soft Speech	_____ Telephone/Cell Phone	_____ Female Voice
_____ Male Voice	_____ Movies	_____In Noisy Settings

Other: _____

_____

Audiological History and Habits: Please answer the following questions Yes/No. If yes, please explain.

Have you ever had pain and/or discharge in your ears?_____

Have you ever had impacted cerumen?_____

Do you have nausea, dizziness, or vertigo?_____

Do you have Tinnitus (ringing or buzzing)?_____

Had you any injuries to your head/ears?_____

Have you ever had ear surgery?_____

Have you had exposure to noise?_____

General Medical History

Have you ever had any serious illness? _____

Have you ever been hospitalized? _____

Are you taking any medications? _____

If yes, list:_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any allergies?_____

Do you have cardiac/circulatory/endocrine or

diabetes?_____

Is there family history of hearing loss? _____

Rehabilitation History

Have you had previous hearing tests ? When and Where?_____

_____

Have you ever worn a hearing aid? _____ ?Type_____

How old is your hearing aid? _____

Have you been seen by an ear doctor? _____

Please give name and date: _____