

AUDIOLOGY CASE HISTORY

Name: _____ Date of Birth: _____

Do you have a hearing problem? (please check) YES NO

Which ear? RIGHT LEFT BOTH

When did it start? _____

Has it gotten worse? NO YES: GRADUALLY SUDDENLY

Have you had a hearing test before? YES NO

When & where? _____

What were the results? _____

History of noise exposure?

Occupational YES NO

When were you exposed to this noise? _____

What types of noise were you exposed to? (e.g. factory, construction, machine shop)

Hearing protection worn? YES NO SOMETIMES

Recreation YES NO

When were you exposed to this noise? _____

What types of noise were you exposed to? (e.g. hunting, chainsaws, power tools)

Hearing protection worn? YES NO SOMETIMES

History of noise in your ears (tinnitus)? YES NO

Which ear? RIGHT LEFT BOTH

When did this start? _____ How frequently? ALWAYS SOMETIMES

How much does it bother you? (1-very little, 5-intolerable) 1 2 3 4 5

Do you have a history of dizziness? YES NO

Sensation? SPINNING FALLING FLOATING UNSTEADINESS

When did you first notice it? _____ What causes it? _____

How long does it last? _____ How often does it occur? _____

Do you have a history of ear pain, pressure (fullness), drainage, surgery, infections? YES NO

Which ear? RIGHT LEFT BOTH

When? _____ Symptoms: _____

Treatment: _____

Family history of hearing loss?

YES

NO

Relationship & cause: _____

History of skull fracture, concussion, or unconsciousness?

YES

NO

Describe specific incidents including dates and circumstances: _____

Have you ever worn hearing aids before?

NO

YES: BOTH RIGHT LEFT

Style: Behind-the-ear (BTE) In-the-ear (ITE) Other: _____

When and where obtained: _____

What did you like or dislike about previous hearing aid? _____
