

**AUDIOLOGY HISTORY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Referred By: \_\_\_\_\_ Practice Name: \_\_\_\_\_

What brings you in today? \_\_\_\_\_

Do you think you have a hearing problem?	Yes	No	Unsure
Which ear?	Right	Left	Both
Which do you think is your better hearing ear?	Right	Left	Same
When did you first notice your hearing problem?	_____		
Has the hearing loss been...	Sudden	Gradual	Fluctuating
Is there a history of hearing loss in your family?	Yes	No	Unsure
If yes, which member has the hearing loss?	_____		
What caused their hearing loss?	_____		

Check all that apply:

- |                                                            |                                                                         |
|------------------------------------------------------------|-------------------------------------------------------------------------|
| <input type="checkbox"/> Frequent Ear Infections           | <input type="checkbox"/> Frequent Colds/Allergies/Sinus Problems        |
| <input type="checkbox"/> Drainage from Ears                | <input type="checkbox"/> Headaches                                      |
| <input type="checkbox"/> Sudden Loss of Hearing            | <input type="checkbox"/> Vision Problems                                |
| <input type="checkbox"/> Ear Pain, Swelling, or Tenderness | <input type="checkbox"/> Head Trauma/Loss of Consciousness              |
| <input type="checkbox"/> Fullness/Pressure in Ears         | <input type="checkbox"/> Diabetes                                       |
| <input type="checkbox"/> Head, Neck, Ear Surgery           | <input type="checkbox"/> Acoustic Trauma (Gunfire, Extreme Loud Noises) |

*Turn over and complete back page*

