AuD: _____

Asheville Head Neck & Ear Surgeons, PA

ADULT AUDIOLOGICAL HISTORY

ID#_____
(For Office Use Only)

Legal Name: _____ _____ _____
First Middle Last

Preferred Name: _____ Date Of Birth: ___/___/___ Age: _____ Sex: M F

Do you think you have a hearing problem? □ Yes □ No □ Not Sure If Yes, which ear? □ Right □ Left

Is there a history of hearing loss in your family? □ Yes □ No □ Not Sure

If yes, which family member(s) have a loss? _____ Cause: _____

Check all that apply:

- □ Frequent ear infections
- □ Draining ears
- □ Ear pain, swelling or tenderness
- □ Fullness or pressure in the ears
- □ Acoustic trauma (gunfire, firecrackers)
- □ Frequent colds, allergies / sinus problems
- □ Visual problems
- □ Skull trauma / loss of consciousness
- □ Head, neck or ear surgery

Please indicate which of the following you have had:

- □ Measles
- □ Mumps
- □ Meningitis
- □ Rubella
- □ Cerebral Palsy
- □ Scarlet Fever
- □ Malaria
- □ Other / Explain: _____
- □ Shingles
- □ Speech / language problems
- □ Bacterial / fungal infection

Have you had / do you have problems with dizziness? □ Yes □ No □ Not Sure

If yes, please check those that apply:

- □ I feel lightheaded
- □ I feel sick to my stomach
- □ I feel like I'm going to fall
- □ Other / Explain _____
- □ I feel off-balance
- □ The room is spinning and I'm still
- □ I feel like I'm spinning and the room is still

When did you start feeling dizzy? _____ Have you consulted a physician? □ Yes □ No

Does any particular body movement cause you dizziness? □ Yes □ No If yes, Please List: _____

Do you have problems with tinnitus (Noise in the ears)? □ Yes □ No □ Not Sure Which ear? □ Right □ Left

Do you have a history of exposure to loud noise? □ Yes □ No □ Not Sure

If yes, please describe the type of noise and how long you were / have been exposed: _____

Do you wear hearing protection? □ Yes □ No

Do you have trouble hearing in any of the following situations:

- □ On the telephone
- □ Watching television
- □ Women's voices
- □ Men's voices
- □ Children's voices
- □ At parties / social groups
- □ At work
- □ With background noise
- □ At religious services
- □ At the movies
- □ At concerts / theatres

Have you ever, or do you currently wear hearing aids? □ Yes □ No Which ear? □ Left □ Right

Are you / were you satisified with them? □ Yes □ No