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? _____