AUDIOLOGY AND HEARING AID CENTER OF GAINESVILLE

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ADULT CASE HISTORY

Patient Name:_____Date of Birth:_____Age:_____
Referred By:_____
Primary Reason for Today's Visit:_____

HEARING

Do you have any problems with hearing? yes / no
Please describe: _____
For how long? ____years ____months
Did the hearing loss begin gradually or was it sudden? _____
Have you ever had your hearing tested? yes / no
If yes, when was your last test and what were the results? _____

Do you have a history of ear infections? yes / no
If yes, how many in one year? _____
Have you ever been evaluated by an ENT/otolaryngologist (ear doctor)? yes / no
If yes, please explain: _____

Do you have ear pain? yes / no
Do you have ear drainage? yes / no
Have you had any ear surgeries? yes / no (if yes, right / left / both)
Describe:_____

TINNITUS (ringing/buzzing/noises in the ear)

Do you have any tinnitus? yes / no If yes, for how long? _____years _____months
Did the tinnitus begin gradually or was it sudden?_____
Please rate your tinnitus (circle one):
Not bad - somewhat noticeable - somewhat interferes - very noticeable - very bothersome - extremely annoying

DIZZINESS/BALANCE

Do you have any dizziness/balance problems? yes / no For how long? _____years _____months
Please describe:_____
Have you previously been treated for dizziness? yes / no

OTHER RELEVANT HEALTH ISSUES

How would you describe your overall health?_____
Do you have any allergies? yes / no
Have you ever been exposed to loud noise? yes / no
Other relevant health history:_____

HEARING AID HISTORY

Have you ever tried a hearing aid? yes / no
Do you currently wear a hearing aid(s)? yes / no If yes, make/model/age:_____
Please describe your most difficult listening situation:_____

Please feel free to add other information you feel would be important for this appointment:_____