ADULT EAR and HEARING CASE HISTORY

Please CHECK YES COLUMN for ALL that apply:

Concerns	YES	Audiologist Notes	Concerns	YES
Gradual Hearing Loss Over how many years? 1-2 3-4 5+ 10+ Hearing Aid use:Yes/No			Loud Sound Exposure *Please circle all that apply:* Factory Military Firearm Power tools Musical instruments Lawn/farm equipment Other:	
Sudden Hearing Loss How many months ago? 0-3 3-6 6-12			Hearing Protection Use Past Present	
One ear hears better? Left Right			Allergy/Sinus problems	
Family history of hearing loss			Cancer treatments	
Ear Surgeries			Diabetes Type: 1 or 2	
Ear Noises (Tinnitus)			High/Low Blood pressure	
Ear pain or drainage in last 90 days			Stroke	
Ear wax build-up			Heart Attack/Pacemaker	
Regular Dizziness			Memory Loss Is PCP aware? Yes/No	

On a scale of 1-10, 1 being poor and 10 being great, how do you rate your hearing? (circle)

1 2 3 4 5 6 7 8 9 10

Please provide a list **OR** list medications:_____

_____

How did you hear about Advanced Audiology?

☐Physician ☐TV ☐Internet ☐Friend/Family_____

Signature below verifies above information is accurate and authorizes Advanced Audiology to perform testing, care and management services relating to my hearing healthcare needs.

Printed Name: _____ Date of Birth: _____ Age:_____

Patient Signature:_____ Date:_____