AMHERSTBURG AUDIOLOGY & HEARING AIDS | The Hearing & Dizziness Clinic

AUDIOMETRIC EVALUATION (HEARING TEST) CASE HISTORY FORM

The following information is confidential.

What brings you in today?_____

GENERAL

Do you think you have a hearing problem?
☐YES ☐NO
If yes, how long have you had this problem?

What do you feel is the cause of your hearing loss?_____

Was the onset: ☐GRADUAL or ☐SUDDEN

In which ear do you feel you hear best?
☐LEFT ☐RIGHT ☐SAME IN BOTH

Is your hearing better some days than others?
☐YES ☐ NO

Have you been exposed to loud noise?☐YES ☐ NO
Did you ever work in noise?☐YES ☐ NO

If yes, please describe:_____

Does anyone in your family have a hearing loss?
☐YES ☐NO
If yes, whom:_____

Have you ever had your hearing tested? ☐YES ☐NO
If yes, when?
Where?
What were the results?

HEARING AID HISTORY

Have you ever worn a hearing aid? ☐YES ☐ NO

If Yes:
How long have you had the hearing aid?
On which ear do you use the hearing aid? ☐ LEFT ☐ RIGHT
Do you wear it regularly? ☐YES ☐ NO
Do you feel you benefit from it?☐YES ☐ NO
List any problems you are having with the hearing aid(s)?

MEDICAL

Have you ever had earaches or drainage from your ears?
☐YES ☐ NO
Have you ever had medical/surgical treatment for your ears?
☐YES ☐ NO
Do you ever feel dizzy or lightheaded?☐YES ☐ NO
Do you notice any noises in your ears?☐YES ☐NO
If yes, which ear:☐ LEFT ☐ RIGHT
Is it bothersome? ☐YES ☐NO
Is it: ☐CONSTANT or ☐INTERMITTENT
When did you first notice this problem?
Have you seen an Otolaryngologist/ENT regarding these noises?
☐YES ☐ NO

Have you ever had any of the following?

- ☐ Meningitis
- ☐ Measles
- ☐ Mumps
- ☐ Scarlet fever
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Seizures
- ☐ Injury to head
- ☐ High Fevers
- ☐ Shingles
- ☐ High blood pressure
- ☐ Vision problems
- ☐ Allergies
- ☐ Pacemaker
- ☐ Arthritis
- ☐ Depression/anxiety
- ☐ HIV/AIDS
- ☐ CMV
- ☐ Communicable disease
- ☐ Chemotherapy

Do you smoke? ☐YES ☐ NO

Do you have any open sores, bleeding or drainage at this time?
☐YES ☐NO

Please list any medications (including non-prescriptions) you are currently taking or have taken recently:

HEARING DIFFICULTIES

Do you have difficulty with any of the following?

- ☐ Watching TV
- ☐ Meetings
- ☐ At the movies
- ☐ Using the telephone
- ☐ Restaurants
- ☐ Church/Worship

Do you have problems hearing the following?

- ☐ Telephone ring
- ☐ Baby Crying
- ☐ Alarm clock
- ☐ Doorbell or Knocking
- ☐ Sirens
- ☐ Fire/Smoke Detector

Which ear do you use on the phone?☐ LEFT ☐ RIGHT
Are you right or left handed? ☐ LEFT ☐ RIGHT
Is there any other information related to your hearing you feel might be important for the Audiologist to know?

☐ By signing below, you consent to an audiometric evaluation and that you have read our privacy policy.

_____
Signature
☐ Self ☐ Parent ☐ POA

Patient Name:
Today's Date: