AUDIOLOGICAL CASE HISTORY



Date Completed		
Last Name	First Name	Date of Birth
1) How did you hear about us?_		
2) Do you have any of the follow	ring? (Circle all that apply.)	
a) Earaches b) Ear drainag	ge c) Ringing or buzzing in your ears	d) Dizziness or lightheadedness
3) Do you have any known allerg	gies? O YES O NO $$ If yes, please list $$ $$	
4) Have you ever had ear surger	ry? O YES O NO If yes, please list date	
5) Do you have any history of m	ajor medical events (i.e. heart attack, stro	oke, diabetes, pacemaker, etc.)?
6) Do you have a history of bein	g exposed to loud noise? O YES O NO)
If yes, please list the loud env	vironments	
	of hearing loss? O YES O NO If yes, p	•
	e difficulty hearing?	
9) What is the cause (if known)	of your hearing loss?	
10) Has there been a change in	your hearing? O YES O NO	
If yes, was the change gradu	ual or sudden?	
11) In what situation do you have	e any difficulty hearing? (Circle all that ap	pply.)
Quiet Noise Restaurants Ch	nurch Theater Telephone Meetings Crov	vds Social gatherings Sporting events
12) Have you ever or do you curi	rently wear hearing aids? O YES O NO	
If yes, what type: BEHIND TH	HE EAR or IN THE EAR? Which ear? L	EFT RIGHT BOTH
13) What did you like or dislike a	about your hearing aids?	
14) Please add any additional in	formation that you feel is important which	h was not addressed above: