NORTHERN ILLINOIS UNIVERSITY
SPEECH-LANGUAGE-HEARING CLINIC
DeKalb, Illinois 60115
815-753-1481 (P) 815-753-1664 (F) 815-753-2000 (TTY/TDD)

Appointment Date: ____ /____ / _____
Time: _____
File / Chart # _____

ADULT AUDIOLOGY HISTORY

Name: _____ Gender: Male / Female / Other

Address: _____ Date: _____

City: _____ State: _____ ZIP: _____ Date of Birth: _____

Telephone: _____ Age: _____

Alternate Phone: _____ Referral: _____

PRESENT EXPERIENCE

Why did you schedule this appointment? _____

_____

When did you first notice difficulties? _____

Do you know what caused the problem? _____

Do you think you have a hearing problem? YES / NO / NOT SURE ❑ Right Ear ❑ Left Ear

Has it been: ❑ Gradual ❑ Sudden ❑ Fluctuating Do you have a *better* ear? ❑ Right Ear ❑ Left Ear

Have you had your hearing tested before? YES / NO When? _____ Where? _____

What were the results?

MEDICAL HISTORY

Family Physician: _____

Ear/Nose/Throat (ENT) Physician (if any): _____

Please check any of the following that YOU *have now* OR *have had* in the past:

- ❑ Allergies
- ❑ Arthritis
- ❑ Asthma
- ❑ Bell's Palsy
- ❑ Diabetes
- ❑ Dizziness/Imbalance
- ❑ Draining Ears
- ❑ Ear Infections
- ❑ Fullness in Ears
- ❑ Headaches
- ❑ Head Injury
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV
- ❑ Kidney Disease/Infection
- ❑ Malaria
- ❑ Measles
- ❑ Meningitis
- ❑ Mumps
- ❑ Neurological Symptoms
- ❑ Parkinson's
- ❑ Scarlet Fever
- ❑ Sinusitis
- ❑ Other:
- ❑ Skin Tags or Pits Near Ear(s)
- ❑ Stroke / TIA
- ❑ Tinnitus (ringing or other sounds in the ears)
- ❑ Tuberculosis
- ❑ Visual Problems

Ear Surgery? *(specify)*: _____ *(when)* _____

Do you take any medications on a regular basis? *(please list, including herbs)*

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

For five or more prescriptions, please allow us to make a photocopy of your medication list

NOISE HISTORY

Workplace Noise Exposure (jobs where you were exposed to loud noise levels) ❑ NONE

Employer / Location	Type of Noise	Length of Employment	Ear Protection?
1.			YES / NO
2.			YES / NO
3.			YES / NO

Military Service? YES / NO Combat Veteran? YES / NO Years of Service: _____

Have you EVER participated in / used any of the following: *(check all that apply)*

❑ Chain Saw ❑ Farm Equipment ❑ Lawn Care Equipment ❑ Recreational Vehicles
❑ Firearms ❑ Woodworking Tools ❑ Other:

When in high noise areas, **you use hearing protection** …

❑ NEVER ❑ SOMETIMES ❑ OFTEN ❑ USUALLY ❑ ALWAYS

Type of hearing protection used: ❑ Muffs ❑ Plugs (foam) ❑ Plugs (flanged/tree) ❑ Other

Have you been exposed to noise in the past 14 hours? YES NO

If yes, did you wear ear protection during the entire time? YES NO

HEARING LOSS DETAIL

Which number from 10-0 best describes your hearing?

10 9 8 7 6 5 4 3 2 1 0

Excellent Hearing Average Hearing No Hearing

Do you have difficulties hearing …

❑ Television ❑ Small Groups ❑ One-on-One Conversations
❑ Telephone ❑ Lecture Halls/Meeting Rooms ❑ Theater or Movies
❑ Church/Temple/Synagogue etc. ❑ Other:

Do family/friends/co-workers feel you are having trouble hearing? YES NO

Have your activities changed because of your hearing? YES NO

If so, how?

Is there a family history of hearing loss? (*if so, who, and when it started*) YES NO

HEARING AID DETAIL

Are you interested in hearing aids if recommended? *YES NO

Have you ever worn a hearing aid? YES NO

❑ Left Ear ❑ Right Ear ❑ Both Ears

Do you **currently wear** your hearing aid(s)? YES NO

How long have you had/did you have your hearing aid(s)? _____

What style is/was your hearing aid(s)? ❑ Behind-the-Ear ❑ In-the-Ear

What did/do you like about your hearing aid(s)? _____

What did/do you dislike about your hearing aid(s)? _____

Where did you purchase your hearing aid(s)? _____

TINNITUS DETAIL (*if no tinnitus, please skip this section*)

Some people experience *tinnitus*, a ringing, buzzing, or other sound hearing that isn't present in the environment.

Do you experience tinnitus? YES NO

When did you first notice it? _____

Did it start … GRADUALLY SUDDENLY

Was there any specific event or change in medication when it started? YES NO

If yes, please explain: _____

How would you describe your tinnitus?

- ❑ Constant
- ❑ Comes & Goes
- ❑ Pulses
- ❑ Steady Volume
- ❑ Changes in Volume
- ❑ Right Ear
- ❑ Left Ear
- ❑ Both Ears / In the Head
- ❑ High-Pitched
- ❑ Low-Pitched
- ❑ Buzzing
- ❑ Ringing
- ❑ Like a Heartbeat
- ❑ More Than One Sound
- ❑ Other:

How hard is it for you to ignore the tinnitus when it is present?

- ❑ Can easily ignore it
- ❑ Can ignore it with some effort*
- ❑ It takes great effort to ignore*
- ❑ Can never ignore it*

DIZZINESS DETAIL (*if no dizziness, please skip this section*)

Some people experience fuzziness, lightheadedness, a sensation of floating or spinning, or the feeling that the room or objects are spinning around them.

How would you describe your dizziness? _____

Is your dizziness more constant/ongoing, or episodic? CONSTANT EPISODES

When did it first start? _____

Do you know the cause? _____

Have you sought treatment for it? From whom? _____

Was there any specific event or change in medication when it started? YES NO

If yes, please explain: _____

If in episodes, how often do they occur? _____

If in episodes, how long do they last? *(circle one)*
< 90 seconds a few minutes a few hours
most of a day a few days _____

Is it associated with a change in position? YES NO

Do you tend to lose balance or veer when walking? YES NO

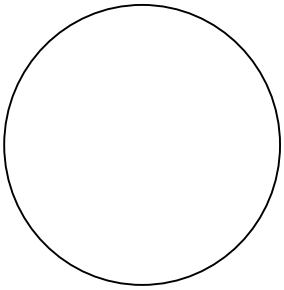
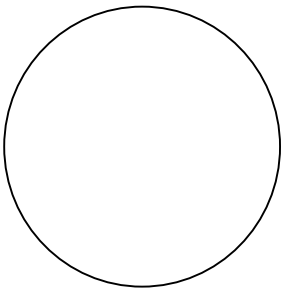
Do you have any special needs of which we should be aware? _____

Is there any other information you feel would be helpful to your evaluation/treatment?

_____

_____

FOR AUDIOLOGY USE ONLY

OTOSCOPY SKETCH	REFERRAL FACTORS	YES	NO
 RIGHT EAR  LEFT EAR	Occluding cerumen or foreign body	❑	❑
	Deformity of the ear	❑	❑
	Pain or discomfort in the ear	❑	❑
	Acute or chronic dizziness	❑	❑
	Active drainage within 90 days	❑	❑
	Rapidly progressive hearing loss within 90 days	❑	❑
	Sudden unilateral hearing loss within 90 days	❑	❑
	Air/bone gap ≥15dB @ 500, 1K & 2K Hz	❑	❑
	Asymmetric hearing loss (PTA of 500,1K,2K,3K difference ≥15dB) *per FDA, clarified by AAO-HNS	❑	❑
	Interaural difference of ≥ 25dB @ 2 adjacent frequencies *per NHCA criteria	❑	❑
	Bilateral HL >90dB HL *per AAO-HNS, not FDA	❑	❑
	Statistically significant (re Raffin/Thornton) difference between ears on WRec *per best practice guidelines	❑	❑

HISTORY NOTES:

EVALUATION NOTES:

RECOMMENDATION NOTES: