**Audiology History**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Legal Name</td>
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<tr>
<td>Preferred Name</td>
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<tr>
<td>With Whom Do You Live?</td>
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<tr>
<td>Street Address</td>
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<td>City</td>
<td>State</td>
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<td>Zip</td>
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<tr>
<td>Telephone</td>
<td>Alternate Phone</td>
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</table>

**Best Method of Contact**

<table>
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<tr>
<th>Phone (may we leave a message?)</th>
<th>Text</th>
<th>Email</th>
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<tbody>
<tr>
<td>Yes / No</td>
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**Primary Physician**

- Ear, Nose, Throat (ENT)
- Physician (if any):  

**Present Concerns**

1. Who referred you here?
2. Why did you schedule this appointment?
3. When did you first notice difficulties?
4. Do you know what caused the problem?
5. What testing have you done for the problem?
6. What were the results?

**Hearing Experience Detail**

1. Do you think you have a hearing problem? NO YES: RIGHT EAR LEFT EAR BOTH
2. If so, has it been? GRADUAL SUDDEN FLUCTUATING
3. Do you have a better ear? BOTH ARE SAME RIGHT EAR LEFT EAR
4. Which number from 0-10 best describes your hearing? 0 1 2 3 4 5 6 7 8 9 10
5. No Hearing
6. Perfect Hearing

7. What are your two most challenging listening situations?
   1. 
   2. 

8. Do your friends/family/coworkers feel you are having trouble hearing? YES NO
9. Have your activities changed because of your hearing? YES NO

**Today’s Date:**
MEDICAL HISTORY

The ears are linked with many bodily systems. All questions asked are important. Please answer completely.

Have you ever been diagnosed with, or have reason to suspect you may have had, any of the following?

- Addiction
- Diabetes
- High Cholesterol
- Scarlet Fever
- Seizures
- Sickle Cell Disease
- Sinusitis (Chronic)
- Skin Condition
- Skin Tag/Pit Near Ears
- Sleep Disorder
- Stroke / TIA
- Tingling in Extremities
- Thyroid Disorder
- Tinnitus
- Tuberculosis
- Vertigo
- Visual Problems

Do you limit or carefully control what you eat?

- YES
- NO

Have you ever tried to intentionally hurt yourself?

- YES
- NO

Please explain any conditions that are marked above.

Have you been diagnosed with or treated for any serious conditions not listed above?

Have you ever had surgery on/in/around your ears?

When and for what condition?

- YES
- NO

Have you been hospitalized or had surgery in the last 5 years?

If so, for what condition?

- YES
- NO

Have you ever been pregnant?

If so, please specify when.

- YES
- NO

Is there a history of hearing loss in your family? In whom? One/both ears? At what ages did it begin?

Of what conditions have your close family members died (if applicable)?

Please list ALL daily medications, including supplements and over-the-counter drugs.

We would be happy to make a copy of your list, for your convenience.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Taken For</th>
<th>Dose/Time</th>
<th>Medication</th>
<th>Taken For</th>
<th>Dose/Time</th>
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</table>
**BALANCE EXPERIENCES**
Do you have any experiences of dizziness, lightheadedness, off-balance, etc.?  
*If so, please describe.*

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<tr>
<th>YES</th>
<th>NO</th>
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**SOUND EXPERIENCES**
Does sound ever bother you?  
*If so, please describe.*

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<th>YES</th>
<th>NO</th>
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Do you hear any sounds that aren’t present in the environment (i.e. “tinnitus”)?  
*If so, please describe:*

<table>
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<tr>
<th>Hardly Notice It</th>
<th>Sometimes Bothersome</th>
<th>Takes Effort to Ignore</th>
<th>Hard to Cope</th>
<th>Cannot live with it</th>
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<tr>
<th>Military Service?</th>
<th>YES</th>
<th>NO</th>
<th>Branch &amp; MOS</th>
<th>Length of Employment</th>
<th>Combat?</th>
<th>YES</th>
<th>NO</th>
<th>Years</th>
<th>Noise?</th>
<th>Hearing Protection?</th>
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Have you ever (home or work) participated in/used any of the following?  
☐ Lawn Care  ☐ Farming  ☐ Music Performance  ☐ Motorcycles/ATVs  
☐ Firearms/Guns  ☐ Woodworking  ☐ Other:

When in high noise areas, you use hearing protection …  
Type of hearing protection used:  
0% ----- 25% ----- 50% ----- 75% ---- 100%

Have you been exposed to noise in the last 14 hours?  
*If so, did you wear hearing protection the entire time?*

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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**AMPLIFICATION EXPERIENCES**
Are you interested in hearing aids, if recommended?  
*If yes, which ear(s)?*  
RIGHT EAR  LEFT EAR

Have you ever worn a hearing aid(s)?  
Do you currently wear your hearing aid(s) regularly?  
Where/when were you fitted with your hearing aid(s)?  
What style is/was your hearing aid(s)?  
What did/do you like about your hearing aid(s)?  
What did/do you dislike about your hearing aid(s)?

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

Is there any other information you feel would be helpful?
RED FLAGS FOR REFERRAL

- Occluding cerumen/foreign body
- Previously undiagnosed deformity of ear
- Pain/discomfort in ear
- Acute/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 difference ≥ 15dB for ave 500, 1K, 2K, 3KHz)
- Interaural difference ≥ 25dB @ 2 adjacent frequencies
- Newly diagnosed/worsened bilateral HL >90dB HL
- Statistically significant difference between ears on WREC testing

Notes: