Audiology History Form

Full Name:

Reason for referral:

Referred by:

Birth Date: Age:

1. Do you have difficulty hearing? _____yes _____no
   If yes, _____right only _____left only _____both

2. Have you ever had a hearing test? _____yes _____no
   If yes, where?

3. Do you currently or have you ever worn hearing aids? _____yes _____no
   If yes, what model and how long?

4. Have you ever worked or are you currently working in a noisy environment? _____yes _____no
   If yes, what company and for how long?

5. Do you shoot guns or have you ever been exposed to gunfire or explosions? _____yes _____no
   If yes, how often?

6. Have you worked in the military? _____yes _____no
   If yes, what was your job? ____________________________ How long?

7. Have you had repeated exposure to any of the following? Please check all that apply.
   - loud music
   - power tools
   - chain saws
   - motorcycles
   - hammering
   - other
   - auto body repair
   - fireworks
   - none of these

8. Please check if you have had any of the following problems.
   - ear infections
   - mastoid problems
   - ear pain
   - dizziness
   - punctured eardrum
   - head injury
   - ear surgery
   - ear drainage
   - other
   - wax problem
   - ringing one/both ears
   - none
   - sudden hearing loss
   - pressure/fullness

9. If you checked any of the problems above, has a physician treated you? _____yes _____no
   If yes, by whom?

10. Is there a family history of hearing loss? _____yes _____no
    If yes, what type of loss did they have?

11. Have you been exposed to noise within the last 14 hours? _____yes _____no
    If yes, did you wear hearing protection?