Full Legal Name: _____ **Date of Birth:** _____

Mailing Address: _____

Preferred Contact Number: _____ **Alternate Contact Number:** _____

Email Address: _____ **Social Security Number:** _____

Do you require a sign language interpreter? *Yes No* ***If yes, please see front desk to provide more information.***

How did you hear about us? *Referred by* _____ *Other:* _____

Reason for Appointment: _____

How long have you had this problem? _____

Who is your primary health provider and/or ENT? _____

Allergies (food, medications, plastics, etc.):_____

Do you currently use tobacco? *Yes No* | Alcohol? *Daily Occasionally No* | Caffeine? *Daily Occasionally No*

Audiologic History

Circle your answers to the following questions to the best of your ability.

Are you currently having a difficult time hearing? *Yes No* Which ear? *Right Left Both*

If you answered yes, which best describes it? *Gradual Fluctuating Sudden*

When did you first notice the difficulty? _____

What do you think is the cause of your decline in hearing? _____

Have you had a hearing evaluation? *Yes No* When/Where? _____

What were the results of the evaluation? _____

Have you ever worn or tried amplification? *Right Ear Left Ear Both Ears No*

What type and/or style of device? _____

Please describe your experience: _____

Do you have a cochlear implant? *Right Left Bilateral No*

Where/when were you implanted? _____

What model of internal and external device do you have? _____

Briefly explain below situations where you feel you may be struggling with hearing. For example, restaurants, background noise, television, telephone, one-on-one conversation, etc.

1. _____
2. _____
3. _____
4. _____

Continues on second page

FOR AMPLIFICATION/COCHLEAR IMPLANT WEARERS:

Do you experience any of the following with your current device(s)? Please check all that apply:

__ Some sounds are too loud
__ Sounds are too soft
__ Pain: _____
__ Sounds are tinny or metallic
__ Trouble understanding in quiet
__ Wind noise
__ Trouble using the telephone
__ Feedback or whistling
__ Trouble understanding in noise
__ Do not like appearance of device
__ Do not like sound of own voice
__ Cannot tell direction of sound

Medical History

Mark the following issues to the best of your ability as it relates to your hearing health.

__ Developmental Disorders/Delays: Please explain: _____

__ Dizziness or Unsteadiness Accompanied by *Vomiting Nausea Ear Noise Falling*
Is the sensation *Constant Episodic (comes and goes)*

__ Ear Deformity *Right ear Left ear Both ears*

__ Ear Drainage *Right ear Left ear Both ears*

__ Ear Pain *Right ear Left ear Both ears*

__ Family History of Hearing Loss Who? _____

__ History of Ear Infections *Right ear Left ear Both ears* If so, when? _____

__ History of Ear Wax Buildup Last removed by doctor: _____

__ Occurrences of Loud Noises What/When? _____

__ Previous Ear Surgery *Right ear Left ear Both ears* If so, when? _____

__ Tinnitus/Ringing/Noise in Ears *Right ear Left ear Both ears* Frequency? _____
When did it begin? _____ Describe: _____

__ Punctured Ear Drum *Right ear Left ear Both ears* Surgery? _____

__ Other: _____

List any other illnesses, surgeries, injuries, or hospitalizations of the head and neck since birth and date(s) of occurrence:

_____

_____

_____

Please indicate any of the following medical conditions to the best of your ability:

__ AIDS/HIV
__ Arthritis
__ Blood Disorders
__ Cancer
__ Chicken Pox
__ Chemotherapy
__ Regular MRI
__ Encephalitis
__ Fatigue
__ Genetic Disorders
__ Headaches
__ Head Injury
__ Heart Problems
__ Contact Dermatitis
__ High Blood Pressure
__ High Fevers
__ Measles
__ Meningitis
__ Mumps
__ Stroke
__ Exostosis
__ Tonsillitis
__ Typhoid
__ Vascular Problems
__ Auto Immune Disorder
__ Radiation Therapy
__ Bleeding Disorder
__ Implantable Device

__ Diabetes *Insulin-dependent or uncontrolled?* _____

__ Other: _____

List all current medications (over the counter, prescriptions, or recreational):

_____

_____

_____

For audiologist use only: