AUDIOLOGIC CASE HISTORY FORM

Name: ____ Date of Birth: ____________________

Do you feel you have a hearing loss? (check one) **Yes** **No**

If you have a hearing loss, how long have you noticed this? ______________________________

Which ear is worse? (check one if applicable) **LEFT** **RIGHT**

Do you have difficulty understanding: (check all applicable)

TV **TELEPHONE** **GROUP SETTINGS** **CERTAIN VOICES**

Have you had your hearing tested before? **Yes** **No**

If yes, when was the last time your hearing was tested? _________________________________

Any drainage from your ears within the past 3 months? **Yes** **No**

Have you experienced dizziness, balance problems, or falls? **Yes** **No**

Have you had any pain or discomfort in your ears within the past 3 months? **Yes** **No**

Have you ever *suddenly* lost your hearing? **Yes** **No**

Do you experience noises or ringing in your ears? **Yes** **No**

If yes, describe it? ____

When did you first notice it? ____

Is the noise: **Constant** **Intermittent (comes and goes)**

Does it keep you up at night? **Yes** **No**

Have you been exposed to loud noise? **Military** **Occupation/Job** **Recreation**

If yes, describe the type of noise ____

Did you wear hearing protection? **Yes** **No**

Is there a history of hearing loss in your immediate family? **Yes** **No**

If yes, who? ____

Have you ever worn hearing aids? **Yes** **No** If yes, how long? ________________________

Signature: ____ **Date:** _____________

Thank you!