Aberdeen
Audiology Live life loud and clear.

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HISTORY FORM

Name: ____ DOB: ____________ Date: _______________

Address:____ City: ________ State: _____ Zip____________

Telephone: _____________________________ Email: _______________________________________

Reason for today's visit ____

Otologic History
(Ear problem includes: ear infections, ear aches, draining ears, medicine taken for ear problem, doctor noticed fluid behind the eardrum, hole in eardrum, etc.)

1. How many ear problems have you had?
   None _____ 1-2 _____ 3-5 _____ 6-10 _____ 10 or more _____

2. Have you had an ear problem in the last 6 months? …………………………………………………Yes No
   If yes, when? ____________ What type of ear problem? __________________________________
   Was medication given? ………………………………………………………………………… Yes No

3. Do you have any of the following?
   - Frequent runny nose ………………. Yes No
   - Frequent colds or sinus infections … Yes No
   - Allergies …………………………... Yes No
   - Ringing or buzzing in the ear(s) ….. Yes No
   - Dizziness …………………………. Yes No

4. Have you ever been seen by and Ear, Nose, and Throat (ENT) doctor? ……………………………Yes No
   If yes, which doctor? _________________________________ When? ________________________

5. Have you ever had any ear surgery? ………………………………………………………………. Yes No

6. Have you previously had your hearing tested by an audiologist? ……………………..................Yes No
   If yes, by whom? _____________________________________ When? _______________________
   What were the results?

7. Do you have any permanent hearing loss? If yes, describe ……………………………..................Yes No

   Have you ever used amplification? …………………………………………………………Yes No

Family History

1. Is there a family history of hearing loss? …………………………………………………………Yes No
   If yes, explain.

General Health History

1. Do you have any major medical conditions? ……………………...……………………………. Yes No
   If yes, explain.

2. Are you taking any medications? ……………………..………………………………………..……… Yes No
   If yes, please list.

3. Have you had any serious illnesses or accidents? ………………………………………………. Yes No
   If yes, describe.

Listening and Understanding

1. Do you think you have a problem listening or understanding speech? ……………………………. Yes No
   If yes, give examples.

   How long have you been aware of this problem?