AUDIOLOGICAL CASE HISTORY

HILLCREST HEARING & BALANCE CENTER
A DIVISION OF SOUTHWEST OHIO ENT SPECIALISTS

Date Completed _____

Last Name _____ First Name _____ Date of Birth _____

1) How did you hear about us? _____

2) Do you have any of the following? (Circle all that apply.)

a) Earaches b) Ear drainage c) Ringing or buzzing in your ears d) Dizziness or lightheadedness

3) Do you have any known allergies? ❍ YES ❍ NO If yes, please list _____

_____

4) Have you ever had ear surgery? ❍ YES ❍ NO If yes, please list date, which ear, and type of surgery. _____

_____

5) Do you have any history of major medical events (i.e. heart attack, stroke, diabetes, pacemaker, etc.)? _____

_____

6) Do you have a history of being exposed to loud noise? ❍ YES ❍ NO

If yes, please list the loud environments. _____

7) Do you have a family history of hearing loss? ❍ YES ❍ NO If yes, please explain. _____

_____

8) When did you first experience difficulty hearing? _____

9) What is the cause (if known) of your hearing loss? _____

10) Has there been a change in your hearing? ❍ YES ❍ NO

If yes, was the change gradual or sudden? _____

11) In what situation do you have any difficulty hearing? (Circle all that apply.)

Quiet Noise Restaurants Church Theater Telephone Meetings Crowds Social gatherings Sporting events

12) Have you ever or do you currently wear hearing aids? ❍ YES ❍ NO

If yes, what type: BEHIND THE EAR or IN THE EAR? Which ear? LEFT RIGHT BOTH

13) What did you like or dislike about your hearing aids? _____

_____

14) Please add any additional information that you feel is important which was not addressed above:

_____

_____