A Division of Southwest Ohio ENT Specialists

AUDIOLOGICAL CASE HISTORY

Name: ______________________________ Date: ______________
First Last MI

Date of Birth: ________________ Age ______________

Address: ____
Street City/State Zip

Home Phone: __________________ Work Phone: ________________

Marital Status: __________ Occupation: ____________________

Social Security Number: ______________________________

Emergency Contact: ______________________________
Name Relation Phone #

Family Physician: ______________________________

Who referred you to this office? ______________________________

Why were you referred to this office? ______________________________

Name and Relationship of person completing form: ______________________

Have you been seen by a medical doctor? ☐ Yes ☐ No If yes, please provide name and address of the Doctor: ______________________________

____

Have you ever been to Hillcrest Hearing Aids & Balance Center before? ☐ Yes ☐ No

Do you have insurance that includes hearing aid coverage? ☐ Yes ☐ No
If so, please list name of company ______________________________

MEDICAL HISTORY

When did you first experience difficulty hearing? ______________________

Have you had a change in your hearing? ☐ Yes ☐ No

Has the change in your hearing been gradual? ☐ Yes ☐ No Sudden? ☐ Yes ☐ No

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

Do you hear better in: ☐ Quiet ☐ Noise

Do you hear on the telephone? ☐ Yes ☐ No

Do you have earaches? ☐ Yes ☐ No If so, which ear? ☐ Left ☐ Right

Do you have ear drainage? ☐ Yes ☐ No

Do you have ringing in your ears? ☐ Yes ☐ No If so, which ear? ☐ Left ☐ Right

Do you experience dizziness? ☐ Yes ☐ No Is your dizziness spinning? ☐ Yes ☐ No

Do you experience lightheadedness? ☐ Yes ☐ No

Do you experience dizziness when you change position? ☐ Yes ☐ No

Please check the following that are associated with your dizziness:

☐ Nausea ☐ Vomiting ☐ Hearing
☐ Change/Vision Problems ☐ Fullness in Ears ☐ Other ____________________

Do you have any known allergies? ☐ Yes ☐ No If so, please list ____________________

____

Are you currently taking any medication?_ ☐ Yes ☐ No If so, please list: ______________

____

Have you had major surgery? ☐ Yes ☐ No If so, please list type and date: ____________

____

Have you had a history of being exposed to noise? ☐ Yes ☐ No If so, please list:

____

____

Do you wear ear protection? (ear plugs, ear muffs, etc.) ☐ Yes ☐ No

Have you ever had a head injury? ☐ Yes ☐ No

Do you have a family history of hearing loss? ☐ Yes ☐ No If so, please explain ________

____

Do you currently wear hearing aids? ☐ Yes ☐ No

If so, what type? ☐ Body ☐ Behind the ear ☐ In the ear

Make: ____________________________ Model: ____________________________________

Serial #: _______________________________ Which ear? ☐Right: ☐ Left: ☐Both

Age of hearing aid(s):____

Have you ever worn hearing aids? ☐ Yes ☐ No

Please provide any other information which might be helpful.