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ADULT AUDIOLOGY HISTORY

Name: _____ Date: _____

Date of Birth: _____ Age: _____

What is the reason for today's visit? _____

Medical / Audiologic History

How is your general health? (please circle) Excellent Good Fair Poor

Please describe _____

Do you have a history of diabetes? Yes No

Are you taking any medications? Yes No (If yes, please list)

Medication	Reason taken
_____	_____
_____	_____
_____	_____
_____	_____

Have you had any recent hospitalizations or surgeries? Yes No

If yes, please describe _____

Do you have a history of ear disease? _____

Do you have a family history of hearing loss? _____

Do you have a history of trauma to the head? _____

Do you have dizziness, vertigo, or loss of balance? Yes No

If yes, please describe:

When did it begin? _____

How long did it last? _____

How often does it occur? _____

Is it accompanied by nausea or vomiting? _____

Do you hear any sounds in your ear (tinnitus)? Yes No

If yes, please describe:

Which ear? _____

When did it begin? _____

How often does it occur? _____

What does it sound like? _____

How long does it last? _____

Do you have a history of noise exposure? Yes No

If yes, please describe _____

Have you ever worn hearing aid(s)? Yes No

If yes, when did you start wearing them? _____

Hearing Difficulty Questionnaire

(please circle)

Listening Situation	Hearing Quality					Importance to You				
	<i>Poor</i>		<i>Normal</i>			<i>Not</i>			<i>Very</i>	
Quiet	1	2	3	4	5	1	2	3	4	5
Television	1	2	3	4	5	1	2	3	4	5
Leisure Activities	1	2	3	4	5	1	2	3	4	5
Restaurants	1	2	3	4	5	1	2	3	4	5
Church	1	2	3	4	5	1	2	3	4	5
Meetings / Groups	1	2	3	4	5	1	2	3	4	5
Work Place	1	2	3	4	5	1	2	3	4	5
Telephone	1	2	3	4	5	1	2	3	4	5
Car	1	2	3	4	5	1	2	3	4	5
Male Voice	1	2	3	4	5	1	2	3	4	5
Female Voice	1	2	3	4	5	1	2	3	4	5
Child's Voice	1	2	3	4	5	1	2	3	4	5
Other (please indicate) _____	1	2	3	4	5	1	2	3	4	5