Wolfe Clinic Audiology Health History Form

First Name ___________________________ Last Name ____________________________DOB ___/____/_____

GENERAL:

Describe what brings you here today: ____

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What question would you like answered today? ____

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If you suspect a hearing loss:

How long have you noticed this problem? ____

Was the onset gradual or sudden? ____

In which ear do you hear the best? Right Left

Please answer the following:

Yes	No	Have you ever been exposed to occupational or recreational noise? (gunfire, music, military) If yes, please describe: ____
Yes	No	Does anyone in your family have hearing loss? If yes, who?: ____
Yes	No	Have you ever had surgical treatment for your ears/hearing? (Tubes, prosthetic, etc.) If yes, when? ____
Yes	No	Have you ever had your hearing tested? If yes, most recently when? ____
Yes	No	Do you notice any tinnitus (for example: ringing, buzzing, roaring) in your ears? If yes, which ear? Right Left Is it bothersome? Yes No Please describe the sound(s) you hear: ____
Yes	No	Do your ears feel a “fullness” or pressure sensation?
Yes	No	Have you had earaches or drainage from your ears within the last 90 days?
Yes	No	Do you ever have dizziness, balance problems or falls?

MEDICAL:

Have you ever or do you currently experience any of the following medical conditions? (Please circle)

Allergies
Arthritis
Blood Disorders
Cancer
(Type/Treatment:___________)
Depression/Anxiety
Dementia

Diabetes
Head Trauma/Concussion
Heart Problems
High Blood Pressure
Kidney Problems
Macular Degeneration
Meningitis

Numbness of hands/fingers
Pacemaker
Seizures
Stroke/TIA
TMJ (jaw joint disorder)
Vascular Problems
Vision Loss

Please list any medications you are currently taking or have taken recently: (or provide list to copy)

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Is there any other information related to your hearing you feel might be important for the Audiologist to know?

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If a hearing aid is recommended, would you like information regarding financial assistance for individuals with limited or restricted income/resources? YES NO

HEARING AID HISTORY:

Have you ever worn or tried a hearing aid? YES NO

Do you use a hearing aid now? YES NO

If yes, how long have you had a hearing aid? ____________________________________

Do you wear it regularly? YES NO

Do you feel you benefit from it? YES NO

List any problems you are having with the hearing aid: ___________________________________

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What would you wish to improve about your current hearing aid? __________________________

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