Audiology Associates of South Florida, Inc.

PATIENT HISTORY NAME: DATE:

PATIENT'S PHYSICIAN:_____
CITY PHONE NUMBER

OCCUPATION (IF RETIRED FORMER):_____

IF THERE WAS AN ILLNESS OR ACCIDENT THAT PRECEDED THE PROBLEM, PLEASE DESCRIBE: _____

WHEN DID YOUR HEARING PROBLEM BEGIN?: _____

FAMILY HISTORY, MEDICAL: _____

FAMILY HISTORY OF HEARING LOSS: _____

DATE AND PLACE OF LAST HEARING TEST: _____

HAVE YOU EVER SEEN AN EAR/NOSE/THROAT SPECIALIST? IF SO WHEN AND WHERE? _____
_____

PLEASE LIST SIGNIFICANT ILLNESSES: _____
_____

PLEASE LIST TYPE AND DATES OF PREVIOUS SURGERIES:_____
_____

DATE AND TYPE OF ANY HEAD TRAUMA: _____
_____

HISTORY OF EAR INFECTIONS: _____ DATE OF LAST INFECTION: _____ ANY DRAINAGE: RIGHT/LEFT_____

LIST OF ALLERGIES: _____

LIST OF MEDICATIONS: _____

VISION PROBLEMS? _____ HISTORY OF HEADACHES? _____

DO YOU HEAR RINGING IN THE EARS? : _____ DESCRIBE:_____

RIGHT EAR _____ LEFT EAR _____ BOTH EARS _____ CONSTANT _____ OCCASIONAL_____

HISTORY OF DIZZINESS? YES_____ NO _____ DESCRIBE: _____

HOW OFTEN DOES IT OCCUR?: _____ BLACKOUTS?: _____NAUSEA? _____

HISTORY OF NOISE EXPOSURE:_____
(TYPE AND DATE) (WORK-RELATED?)

DO YOU USE A HEARING AID? NO____ IF YES, WHICH EAR? _____ TYPE: _____ HOW LONG ?_____

DO YOU HAVE DIFFICULTY LISTENING : TO THE RADIO / TV _____ MOVIES? _____ IN A CAR? _____

AT A DISTANCE? _____ UNDERSTANDING SPEECH? _____ IN GROUPS? _____ TO ONE PERSON ?_____

IN WHAT SITUATION WOULD YOU MOST LIKE TO HEAR AND UNDERSTAND BETTER? _____

IF WE FIND THROUGH THE TESTING THAT YOU CAN BE HELPED ARE YOU READY FOR THAT HELP? _____

WHICH IS YOUR BETTER EAR? RIGHT _____ LEFT _____ UNDETERMINED _____