LAKESIDE AUDIOLOGY
Hearing Solutions for All

Adult History Form

Today's Date: _____

Name: _____ Date of Birth: _____

What is your primary reason for coming in today? _____

_____

If you suspect a hearing loss, how long have you noticed this problem? _____

What do you believe caused your hearing problem? _____

Was the onset of your hearing loss gradual or sudden? ☐ Gradual ☐ Sudden

In which ear do you hear the best? ☐ Right ☐ Left ☐ Same in both ears

Have you ever been exposed to occupational or recreational noise (example: military, music, gunfire)?

☐ YES ☐ NO

If yes, please describe _____

Does anyone in your family have hearing loss? ☐ YES ☐ NO

If yes, who? _____

Have you ever had your hearing tested? ☐ YES ☐ NO

If yes, when? _____

MEDICAL HISTORY:

Have you had earaches or drainage from your ears within the last 90 days? ☐ YES ☐ NO

Have you ever had medical/surgical treatment for your ears? ☐ YES ☐ NO

If yes, please explain: _____

Do you ever have dizziness or balance problems? ☐ YES ☐ NO

Do you notice any tinnitus (ringing, buzzing, or roaring) in your ears? ☐ YES ☐ NO

If yes, which ear? ☐ Right ☐ Left ☐ Both ears

Is it constant, or does it occur occasionally? ☐ Constant ☐ Occasionally

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Please list any medications you are currently taking or have taken recently:

_____
_____
_____

Have you had or do you currently have any of the following? Check all that apply.

☐ High Blood Pressure	☐ Meningitis	☐ Mumps	☐ Vision Problems
☐ Arthritis	☐ Heart Disease	☐ Stroke/TIA	☐ Multiple Sclerosis
☐ Cancer	☐ Diabetes	☐ Kidney Disease	☐ Depression/Anxiety
☐ Measles	☐ Dementia/Alzheimer's		

HEARING HISTORY:

List 3 areas where you have the most difficulty hearing or understanding:

1. _____
2. _____
3. _____

Do you have difficulty hearing/understanding in any of the following situations? Check all that apply.

☐ Watching TV	☐ Restaurants	☐ Meetings
☐ Telephone	☐ Movies	☐ Religious Services

HEARING AID HISTORY:

Do you wear hearing aids? ☐ YES ☐ NO

If yes, which ear uses a hearing aid? ☐ Right Only ☐ Left Only ☐ Both

Do you wear your hearing aid(s) regularly? ☐ YES ☐ NO

Do you feel you benefit from your hearing aid(s)? ☐ YES ☐ NO

List any problems you are having with the hearing aids _____

What would you improve about your current hearing aid technology? _____