Audiology History Form

Full Name: _____
Last *First* *M.I.*

Reason for referral: _____

Referred by: _____

_____

Birth Date: _____ Age: _____

1. Do you have difficulty hearing? _____yes _____no
   If yes, _____right only _____left only _____both

2. Have you ever had a hearing test? _____yes _____no
   If yes, where?_____

3. Do, you currently or have you ever worn hearing aids? _____yes _____no
   If yes, what model and how long?_____

4. Have you ever worked or are you currently working in a noisy environment? _____yes _____no
   If yes, what company and for how long?_____

5. Do you shoot guns or have you ever been exposed to gunfire or explosions? _____yes _____no
   If yes, how often?_____

6. Have you worked in the military? _____yes _____no
   If yes, what was your job? _____ How long?_____

7. Have you had repeated exposure to any of the following? Please check all that apply.

☐ loud music	☐power tools	☐chain saws
☐motorcycles	☐hammering	☐other
☐auto body repair	☐fireworks	☐none of these

8. Please check if you have had any of the following problems.

☐ ear infections	☐mastoid problems	☐ear pain
☐dizziness	☐punctured eardrum	☐head injury
☐ear surgery	☐ear drainage	☐other
☐wax problem	☐ringing one/both ears	☐none
☐sudden hearing loss	☐pressure/fullness	

9. If you checked any of the problems above, has a physician treated you? _____yes _____no
   If yes, by whom?_____

10. Is there a family history of hearing loss? _____yes _____no
    If yes, what type of loss did they have? _____

11. Have you been exposed to noise within the last 14 hours? _____yes _____no
    If yes, did you wear hearing protection? _____