

## AUDIOLOGICAL EXAM HISTORY

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Company: \_\_\_\_\_

Occupation: \_\_\_\_\_

### To be completed by Patient:

Ear-related symptoms:	Yes	No	Right	Left	Both	Patient Comment(s)
Have you recently experienced <b>PAIN</b> in either ear?.....	*	*	*	*	*	
Have you recently experienced a <b>DRAINING</b> ear?.....	*	*	*	*	*	
Have you recently experienced <b>DIZZINESS</b> ?.....	*	*	*	*	*	
Have you recently experienced severe <b>TINNITUS</b> (ringing)?.....	*	*	*	*	*	
Have you recently experienced <b>sudden HEARING LOSS</b> ?.....	*	*	*	*	*	
Have you recently experienced <b>fluctuating HEARING LOSS</b> ?.....	*	*	*	*	*	
Have you recently experienced ear <b>FULLNESS / DISCOMFORT</b> ?	*	*	*	*	*	
Have you recently had problems wearing hearing protection?.....	*	*				

Ear-related Medical History:	Yes	No	Right	Left	Both	Patient Comment(s)
Have you ever been to a doctor for an <b>ear-related problem</b> ?.....	*	*	*	*	*	
Have you ever had <b>ear surgery</b> ?.....	*	*	*	*	*	
Have you ever had an <b>ear injury</b> ?.....	*	*	*	*	*	
Do you have frequent <b>ear infections</b> ?.....	*	*	*	*	*	
Do you wear a <b>hearing aid</b> ?.....	*	*	*	*	*	
Do you have an <b>existing hearing problem</b> ?.....	*	*	*	*	*	
Does any of your immediate family have hearing problems?.....	*	*				

General Medical History:	Yes	No	Patient Comment(s)
Have you ever had kidney disease, diabetes, high blood pressure?..	*	*	
Have you ever had measles, mumps, scarlet fever, or meningitis?...	*	*	
Do you currently use prescription or over the counter drugs?.....	*	*	
Have you ever had a severe head injury?.....	*	*	
Are you currently suffering from allergies?.....	*	*	

Personal History:	Yes	No	Patient Comment(s)
Have you ever served in the military?.....	*	*	
Do you shoot guns or hunt?.....	*	*	
Do you participate in loud activities at home (music, power tools, cars, motorcycles, etc.)?.....	*	*	

Occupational History:	Yes	No	Patient Comment(s)
Are you exposed to noise at your job?.....	*	*	
If yes, do you wear hearing protection as instructed?.....	*	*	
Have you been exposed to noise within the past 14 hours?.....	*	*	
If yes, were you wearing hearing protection?	*	*	

Surveillance Questions:	Patient Comment(s)
When was your last hearing test? _____	
Was it normal?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you have any other comments on the health of your hearing? ☐ Yes ☐ No If Yes, please explain:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Technician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_