Audiology Intake Form (Adult)

Name:_____ Date of visit: ___/___/_____

Referring Physician: _____Occupation:_____

Reason for today's visit:

_____

_____

_____

Previous surgeries and hospitalizations:

_____

_____

Medications (include vitamins, over the counter, herbal):

_____

_____

History of:

Abnormal renal function (kidney problems)	☐ Yes	☐ No
Hypertension (high blood pressure)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Neurological disorder	☐ Yes	☐ No
Migraines	☐ Yes	☐ No

Do you feel you have hearing loss? ☐ Yes ☐ No

If yes:

For how long? _____

In which ear? ☐ Right ☐ Left ☐ Both

Prior use of hearing aids? ☐ Yes ☐ No

If yes:

When? _____

Which ear? ☐ Right ☐ Left ☐ Both

What kind? _____

Were you satisfied with them? ☐ Yes ☐ No

Have you ever had an ear infection or ear surgery? ☐ Yes ☐ No

If yes:

When? _____

Which ear? ☐ Right ☐ Left ☐ Both

Do you ever experience tinnitus (noises in the ears)? ☐ Yes ☐ No

If yes:

For how long? _____

In which ear? ☐ Right ☐ Left ☐ Both

Are the noises constant or intermittent? ☐ Constant ☐ Intermittent

Please describe the noise as best you can:

_____

_____

Do you ever experience dizziness or imbalance? ☐ Yes ☐ No

If yes:

When was the onset? _____

How many episodes? _____

Any vomiting/nausea? _____

Please describe the dizziness: _____

Have you ever been exposed to loud noise? ☐ Yes ☐ No

For how long? _____

Did you wear ear protection? ☐ Yes ☐ No

Have you ever had a head injury? ☐ Yes ☐ No

If yes:

Was there any loss of consciousness? ☐ Yes ☐ No

Do you have hearing loss in your family? ☐ Yes ☐ No

If yes:

Which family member? _____

Cause of hearing loss (if known)? _____