**AUDIOLOGY INTAKE FORM (ADULT)**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Referring Physician:</td>
<td>Occupation:</td>
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</tbody>
</table>

**Reason for today's visit:**

- [ ] 8. Abnormal renal function (kidney problems)
  - Yes
  - No
- [ ] 9. Hypertension (high blood pressure)
  - Yes
  - No
- [ ] 10. Diabetes
  - Yes
  - No
- [ ] 11. Allergies
  - Yes
  - No
- [ ] 12. Neurological disorder
  - Yes
  - No
- [ ] 13. Migraines
  - Yes
  - No

**Medications (including vitamins, over the counter, herbal, etc.):**

**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)? ____________________________