Weill Cornell Medicine
Otolaryngology
Head & Neck Surgery

AUDIOLOGY INTAKE FORM (ADULT)

Name:	Date:
Referring Physician:	Occupation:

Reason for today's visit:

Previous Surgeries and Hospitalizations:

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)? _____