ANDERSON-OCONEE SPEECH & HEARING CLINIC

AUDIOLOGY CASE HISTORY FORM

FULL NAME:_____ **DATE:**_____

ADDRESS:_____ **CITY:**_____ **STATE:**____ **ZIP:**_____

HOME PH: (_____) _____ **CELL PH:** (_____) _____ **E-MAIL:**_____

BIRTHDATE:_____ **AGE:** _____ **GENDER:** Male / Female

RACE: W / B / H /OTHER **PLEASE CIRCLE:** Single / Married / Widowed / Divorced

OCCUPATION_____ **PRESENT JOB**_____

Person filling out the questionnaire (if not the patient):_____

Best Contact Person (if not patient):_____ **Phone:** (_____) _____

Family Doctor:_____ **Specialists (ENT, etc.):**_____

Have you had your hearing tested or seen an ear or hearing specialist in the past? Y / N

If YES, please describe:_____

PLEASE CHECK ALL EAR / HEARING RELATED MEDICAL ITEMS THAT APPLY TO <u>YOU:</u>

○ Allergies ○ Chemo/Radiation ○ Childhood Illness ○ Dementia ○ Diabetes ○ Dizziness/Vertigo ○ Ear wax

○ Ear Infection History ○ Family Hearing Loss ○ Heart Problems ○ Head Injury ○ High Blood Pressure

○ Kidney Disease ○ Meningitis ○ Pain in ear(s) ○ Ruptured eardrum ○ Surgery on ear(s) if YES: R / L

○ Tinnitus (ringing in ears) ○ Thyroid Disease ○ OTHER MEDICAL CONDITION:_____

What is your primary hearing/ear complaint?_____

_____ **How long have you noticed it?**_____

***PLEASE RATE YOUR HEARING FROM 1- 10 (1 BEING THE WORST AND 10 THE BEST):**_____

Have you ever worked around loud noise? Y / N If YES, how long?_____

Noisy hobbies? ○ Gunfire ○ Motorcycle ○ Heavy Machinery ○ Rock Concerts ○ Lawn Work ○ Other

Do you now or have you worn a hearing aid? Y / N If YES, what kind?_____

Who referred you to our clinic?_____ **Physician / Family / Friend / Other**

COMMENTS OR QUESTIONS FOR THE AUDIOLOGIST:

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