Elkhart Audiology Rehab
Better Hearing. Better Living.

Name:_____

Date:_____

Adult History

What is your chief concern about your ears/hearing? _____
Do you suspect hearing loss in your right_____ left____ both ears____ ? If so, for how long?_____
Or has no hearing problem been noted_____?
Do you have tinnitus (noise in your ears)?_____ If so please describe: _____
Has your hearing suddenly changed?_____ If so, when or why _____
Does your hearing seem to fluctuate?_____ Have you had ear wax removed before? _____
Do you have a history of ear aches? _____ infections? _____ discharge? _____
Have you ever been treated by an ear doctor? _____ If so, please describe: _____
_____
Have you been exposed to noise through work or recreational activities? _____
Do you wear hearing protection? _____ If so, what kind? _____

Please check all that apply. I have difficulty: hearing in background noise _____ children _____ co-workers _____spouse _____ radio/TV _____ on the telephone _____at religious services _____ in groups _____ miss the phone ring _____ smoke alarm _____
Do you wear glasses? _____ use oxygen? _____ Which ear do you use on the phone? _____

General Health:
How is your health currently? _____
Any serious physical injury? _____ What _____When _____ _
Please check all that apply:

_____Bell's Palsy	_____Diabetes	_____Dizziness ( )	____Pressure
___ High Blood Pressure	_____ HIV	_____Meningitis	____Headaches
_____Parkinson's	_____Stroke/TIA	_____ Memory issues	

Please list any medications or nutritional/herbal supplements you are taking:

1. Name _____Used for _____
2. Name _____ Used for _____
3. Name _____ Used for _____
4. Name _____ Used for _____

Have any known allergies? _____

Any additional remarks?
_____
_____
_____