Elkhart Audiology Rehab

Name: _____
FIRST/M.I./LAST
Date of Birth: _____
Today's 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? _____
Do you have tinnitus (noise in your ears)? _____ If so please describe: _____
Does the noise last more the 15 min? _____ Does it interfere with sleep or concentration? _____
Check any that you use: _ Tobacco _ Alcohol _ Caffeine
Have you had ear wax removed before? _____ Have you ever been treated by an ear doctor? _____
If so, please describe: _____
Do you have a history of: _ Earaches _ Infections _ Discharge
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 _ In groups
_ On the phone _ At religious services _ The phone ringing _ smoke alarms
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 _____
Medical/ Specialist Physician: _____ Manages: _____
Medical/ Specialist Physician: _____ Manages: _____
Medical/ Specialist Physician: _____ Manages: _____

Please check all that apply:

_ Bell's Palsy	_ Diabetes	_ Dizziness	_ Depression
_ High Blood Pressure	_ Balance/Fall	_ Meningitis	_ Headaches
_ Parkinson's	_ Stroke/TIA	_ Memory issues	_ Pacemaker
_ Chemo treatment	_ Chronic kidney disease		_ Head Injury

Please list any medications or nutritional/herbal supplements you are taking:
(We can make a copy of a list you provide)

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

Have any known allergies? _____

Any additional remarks?
_____
_____