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Doctor of Audiology

Name: _____

DOB: _____

Complaint:

- | | | |
|---|-------|--------|
| 1. Do you have problems hearing? | ___no | ___yes |
| 2. Do family members complain about your hearing? | ___no | ___yes |
| 3. Do you hear noises (tinnitus) in your ears or head? | ___no | ___yes |
| 4. Do you experience dizziness, headaches, or ear pain? | ___no | ___yes |
| 5. Have you had a hearing test before? | ___no | ___yes |
| 6. Have you ever worn a hearing aid? | ___no | ___yes |

History:

- | | | |
|--|-------|--------|
| 1. Does any family member, including cousins, have a hearing loss? | ___no | ___yes |
| 2. Have you ever been exposed to loud noises? | ___no | ___yes |
| 3. Have you ever had a concussion or skull fracture? | ___no | ___yes |
| 4. Have you ever had ear infections? | ___no | ___yes |
| 5. Have you ever had ear surgery? | ___no | ___yes |
| 6. Do you take medications regularly? | ___no | ___yes |
- If yes, for what conditions?

Comments:
