ADULT EAR and HEARING CASE HISTORY

On a scale of 1-10, 1 being poor and 10 being great, how do you rate your hearing? (circle)
1 2 3 4 5 6 7 8 9 10

Please CHECK YES COLUMN for all that apply:

Concerns	YES	Audiologist Notes	Concerns	YES
Gradual Hearing Loss			Loud Sound Exposure *Please circle all that apply:* Factory Military Firearm Musical instruments Lawn/farm equipment Power tools Other:	
Sudden Hearing Loss			Hearing Protection Use	
One ear hears better			Allergy/Sinus problems	
Family history of hearing loss			Cancer treatments	
Ear Surgeries			Diabetes	
Ear Noises (Tinnitus)			High/Low Blood pressure	
Ear pain or drainage in last 90 days			Stroke	
Ear wax build-up			Heart Attack/Pacemaker	
Regular Dizziness			Memory Loss	

Please provide **OR** list medications:_____

_____

How did you hear about Advanced Audiology?_____

Signature below verifies above information is accurate and authorizes Advanced Audiology to perform testing, care and management services relating to my hearing healthcare needs.

Printed Name: _____ Date of Birth: _____ Age:_____

Patient Signature:_____ Date:_____

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Test	Right Ear	Left Ear
Otoscopy	Clear, non/partial/fully occluding	Clear, non/partial/fully occluding
Tympanogram	A B C Large ECV	A B C Large ECV
Reflex	500 | 1000 | 2000 | 4000	500 | 1000 | 2000 | 4000
Decay	Negative Positive	Negative Positive
DPOAE	Present / Absent	Present / Absent
TEOAE	Present / Absent	Present / Absent
Tinnitus Matching	Hz / dBSL / dBSL masked	Hz / dBSL / dBSL masked
WRS errors	/	/
Quick SIN errors	dB / SNR	

R	%	
L	%	

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