



Audiology Adult Patient History Form

Name: _____ **Today's Date:** _____

Address: _____
(Street)

_____ (City) _____ (Zip Code)

Phone: _____ **Date of Birth:** _____

Primary Care Physician: _____

How did you hear about us:

Newspaper , Friend, word of mouth, relative , Premier health newsletter
Health fair screening , Letter of invitation , Doctor referral , Web site ,
Post Card , VIP Newsletter , Other _____

Hearing Sensitivity:

Do you have difficulty hearing or understanding in the Right or Left ear? No .

Do you have an ear you feel is worse? Right Left No .

Was the hearing loss GRADUAL in onset or SUDDEN in onset?

If gradual, how long has it been getting worse? _____

If sudden, what were you doing just prior to it getting worse? (illness, cancer treatment, car accident, etc.) _____

Have you had your hearing tested before? yes no

Hearing Instrument Use:

Have you ever worn hearing aids before? yes no

Tinnitus:

Do you have noises in your ears? yes no

Is the sound in the right or left ear?

Describe the sound: _____

Is the sound constant or does it come and go ?

Does the noise keep you from falling asleep at night? yes , no

On a scale of 1 (no impact) to 10 (ruined), how does it affect your life? ____

Balance:

Do you feel off balance lightheaded a spinning sensation ? No .

When was the onset? _____

Do you feel this constantly or does it come and go ?

If it comes and goes, how long does the feeling last? _____

What initiates the feeling? _____

Aural Fullness:

Do you have feelings of pressure or fullness in either ear? No .

If yes, how often do you experience this feeling? _____

Trauma:

Have you ever had a severe injury to your head? yes no

Have you ever had:	Right ear	Left ear
Punctured eardrum	<input type="checkbox"/>	<input type="checkbox"/>
Ear surgery	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>
Ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Ear drainage	<input type="checkbox"/>	<input type="checkbox"/>

Noise exposure:

Have you ever been exposed to: gunfire , firecrackers , explosions , power tools , occupational noise , lawn mower , other _____

If yes to any of the above, do you use hearing protection? yes no

Were you in the military? yes , no

Family History:

Does any member of your family have a hearing loss? yes no ?

If yes, who _____

Do you know the cause of their hearing loss? yes no

Medications:

Have you ever taken a medication that your doctor said may have an effect on your hearing? _____

Have you ever taken an anticancer (chemotherapy) drug? yes no

If yes, was your hearing monitored during that time? yes no

Communicable Diseases:

Tuberculosis (TB)-Please check all boxes that currently apply:

History

active TB or history of recent TB (even if on meds)

Signs and Symptoms

cough >2 weeks

fever and/or chills and/or night sweats

weight loss >10 pounds

immune compromised (HIV, cancer, chronic illness)

Risk Factors

jail in the past 2 years

recent exposure to TB

foreign born

homeless shelter

Measles:

Have you ever had the measles?

No

Yes

Have you received the measles vaccine?

No

Yes

If no, been exposed with last 2 weeks?

No

Yes

Chickenpox:

Have you ever had the chickenpox?

No

Yes

Have you received the chickenpox vaccine?

No

Yes

If no, been exposed in the last 2 weeks?

No

Yes

Smallpox:

Have received vaccine within past 4 weeks?

No

Yes*

If yes to items marked with (), consult Infection Control for notification only. If consult needed .*

Additional comments:

Thank you for choosing Florida Hospital!