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Phone: 315-624-9273
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ADULT AUDIOLOGY CASE HISTORY

In your own words, please describe the reason(s) for your appointment today:

_____
_____
_____
_____
_____

IDENTIFICATION

Patient Name:_____ Mr. Mrs. Miss Ms. Dr. ____
Last First Middle (Circle One) Other

Date of Birth: _____ Age: _____ Gender (optional): Male or Female

Address:_____
Street City State Zip

Cell Phone:_____ Home Phone:_____

E-Mail:_____

Occupation:_____ Place of Employment:_____

Language(s) spoken by patient:_____

Primary Care Physician:_____

Referred By:_____

Reason for Referral:_____

Emergency Contact:_____

Relation:_____ Phone Number:_____

May we discuss your care with this person? ☐ Yes ☐ No Please Initial Here:_____

(Care includes appointments, test results, and information from appointments in this office only)

_____ _____ _____
Signature of the Person who Completed this Form Relationship to Patient Date Completed

Chahfe Center • 2206 Genesee Street • Suite #303 • Utica, NY 13502

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ADULT AUDIOLOGY CASE HISTORY

Have you ever had your hearing tested before? ☐ Yes ☐ No If, yes

When was your last hearing test and where was it performed? _____

Please check all that apply:

R	L		R	L			
☐	☐	Hearing Loss	☐	☐	Tinnitus(ringing, buzzing)	☐	Dizziness/Imbalance
☐	☐	Ear Surgery	☐	☐	Ear Infections	☐	Head Trauma or Concussion
☐	☐	Ear Injury	☐	☐	Noise Exposure	☐	Sensitivity to Loud Noises
☐	☐	Ear Pain or Pressure	☐	☐	Excessive Ear Wax	☐	Family History of Hearing Loss

Provide any further explanation if needed for checked items above:

_____
_____
_____
_____

Have you ever worn a hearing aid before? ☐ Yes ☐ No If, yes
Are you currently wearing a hearing aid? In which ear(s)? ☐ Right ☐ Left ☐ Both

How long ago and where did you purchase your hearing aid(s)? _____

Are you satisfied with your hearing aid(s)? ☐ Yes ☐ No

If no, why?_____

MEDICAL HISTORY

Present Physical Condition (circle one): (Excellent) 5 4 3 2 1 0(Poor)

Please check any significant health problems experienced:

☐ Stroke	☐ Seizures	☐ Kidney Disease
☐ Cancer	☐ History of Mumps or Measles	☐ Diabetes
☐ Heart Attack	☐ Meningitis	☐ Other:_____
☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Other:_____
☐ Pacemaker	☐ Alzheimer's or Dementia	☐ Other:_____

Have you ever taken any medication that was harmful to your hearing? ☐ Yes ☐ No
Are you taking any prescribed medications? ☐ Yes ☐ No
Are you taking any over the counter medications? ☐ Yes ☐ No

If yes to any of the above, please list:_____
_____
_____

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