

## Adult Audiology History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

How is your general health? \_\_\_\_\_

What current medications are you taking?  
\_\_\_\_\_

Any recent hospitalizations | surgeries? \_\_\_\_\_

History of diabetes? \_\_\_\_\_ History of ear disease? \_\_\_\_\_

Family history of hearing loss? \_\_\_\_\_ History of head trauma? \_\_\_\_\_

Hearing better in left or right ear? \_\_\_\_\_ History of noise exposure? \_\_\_\_\_

Have you ever worn a hearing aid? \_\_\_\_\_

Do you have any tinnitus (ringing, buzzing, hissing or other noises in your ears)? \_\_\_\_\_

Have you experienced dizziness, loss of balance or vertigo? \_\_\_\_\_

Do you have problems with excessive ear wax? \_\_\_\_\_

Any additional info you would like us to know?

Signature \_\_\_\_\_ Date \_\_\_\_\_