Adult Case History

Albrecht Audiology

Date

Contact Information

Patient Name

Birth-date

Street address

Street address line 2

City

State

Zip code

Telephone Number

E-mail Address

Primary Care Physician

Referred by:

Chief Complaint

- ☐ Hearing Loss
- ☐ Difficulty hearing in noise
- ☐ Tinnitus/Ringing
- ☐ Dizziness
- ☐ Other

If Hearing loss:

- ☐ Left Ear
- ☐ Right Ear
- ☐ Both Ears

How long have you noticed this difficulty?

History of Ear Infections? ○ Yes ○ No

History of Ear Surgery? ○ Yes ○ No

Any Drainage from your Ears? ○ Yes ○ No

If any are yes, please Explain?

Have you had any dizziness, lightheadedness, vertigo, or loss of balance? ○ Yes ○ No

If Yes, When did this start?

When did it happen last?

Have you discussed this with a physician? ○ Yes ○ No

Do you take medication for it? ○ Yes ○ No

Do you have any tinnitus (noises in your ears/ head)?
- ○ Yes
- ○ No

Is it in your:
- ☐ Right Ear
- ☐ Left Ear
- ☐ Both Ears
- ☐ Somewhere in Head

The tinnitus is present:
- ☐ Occasionally
- ☐ Often
- ☐ Always

When did it start?

Describe the tinnitus:
- ☐ Roaring
- ☐ Ringing
- ☐ Buzzing
- ☐ Hissing
- ☐ Other

How often can you ignore it?
- ☐ Almost Always
- ☐ Usually
- ☐ Rarely
- ☐ Never

Do you take medications on a regular basis? (Please List or bring a copy with you)

Have you seen an ENT (Ear, Nose, Throat) Specialist? (if yes, please describe)

Please check any of the following that you currently have or have had in the past?
- ☐ Diabetes
- ☐ Heart Trouble
- ☐ Malaria
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Bell's Palsy
- ☐ Head Injury
- ☐ High Blood Pressure
- ☐ Menigitis
- ☐ Visual Problems
- ☐ Measles
- ☐ Parkinson's
- ☐ Stroke/TIA
- ☐ Other

Have you ever been exposed to loud sound, either recently or in the past?

- ○ Yes
- ○ No

If yes, check all the apply:

- ☐ Gunfire
- ☐ Explosions
- ☐ Aircraft
- ☐ Loud Music
- ☐ Weed Eater
- ☐ Farm Machinery
- ☐ Heavy Equipment
- ☐ Motorcycles
- ☐ Factory Noise
- ☐ Power Tools
- ☐ Leaf/Snow Blower
- ☐ Chain Saw
- ☐ Snow mobile/Boat

Have you used hearing protection?

- ☐ Always
- ☐ Sometimes
- ☐ Never

If your chief complaint is hearing, did you lose you hearing?

- ○ Gradually
- ○ Suddenly

Have you had your hearing tested before?

- ○ Yes
- ○ No

If so, when? _____

Does your hearing seem to fluctuate?

- ○ Yes
- ○ No

Are you bothered by loud sounds?

- ○ Yes
- ○ No

If you hearing is your concern for your upcoming visit please also answer our "Hearing Challenges Questionnaire"

If you are a musician please also answer our "Musician's Questionnaire"

If you have ever or are currently using hearing aids, please also answer our "Hearing Aid Questionnaire"

Submit