Audiology Adult History Form:

What is your primary concern?					
Do you have trouble hearing?	Yes	No			
	Is one ear better than the other? Right			Left	Equal
	How long have you had this trouble?				
	Are you looking for a solution to this problem?				
Do you have ringing/buzzing in the ear?	Yes	No			
Do you have ear pain?	Yes	No			
Do you have a feeling or pressure or fullness in your ears?	Yes	No			
Do you have dizziness? Room spinning, you spinning, falling, or loss of consciousness?	Yes	No	Describe:		
Do you have a family history of hearing loss?	Yes	No	Who?		
Do you have noise exposure? Military, hunting, occupational, recreational.	Yes	No	What type of exposure? Did you wear hearing protection?		
Have you been diagnosed with heart disease?	Yes	No			
Have you been diagnosed with a stroke?	Yes	No			
Have you been diagnosed with diabetes?	Yes	No			
Have you been diagnosed with cancer?	Yes	No			
Are you a non-smoker?	Yes	No			
MEDICARE PATIENTS ONLY					
Please review and initial attached medication list	Completed				
EASI (Patient is not required to complete but Medicare requests completion)					
1.Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No			
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aid or medical cere, or from being with people you wanted to be with?	Yes	No			
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No			
4. Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No			
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No			