House of Hearing
An AudiologyHQ Company

Adult Audiological History Form

Full Name _____

Date _____

Reason for visit: _____

1. Do you have or have you had any of the following? (Mark all that apply)

☐ Hearing Problems	☐ Ear Deformity or Injury	☐ Head Injury	☐ Pacemaker
☐ Sound Sensitivity	☐ Ear Drainage	☐ Dizziness	☐ Tobacco Usage
☐ Ear Infections	☐ Pressure / Fullnes in Ear	☐ Punctured Eardrum	☐ Unlisted Problem
☐ Ear Surgery	☐ Sudden Hearing Loss	☐ Stroke	
☐ Ear Pain	☐ Ear Noises / Tinnitus	☐ Diabetes	

2. Do you have any relatives with hearing loss that started before age 70? YES ☐ NO ☐

3. Do your loved ones say that you have a hearing problem? Who? _____ YES ☐ NO ☐

4. When was the last time you had your hearing tested? _____

5. Where was your hearing tested? _____

6. Were you told that you have a hearing problem? _____

7. If you think you have hearing loss, in which situations do you have difficulty hearing?

8. If you have hearing loss, for how long have you noticed it? _____

9. Do you wear or have you worn hearing aids in the past? YES ☐ NO ☐

If yes, when and where did you get them?

_____

If yes, are you currently experiencing problems with them? _____

10. Is there anything else you would like us to know about your hearing?

11. Please list any other medical issues you are currently experiencing.

12. List any medications you are taking (exclude vitamins):