



Albuquerque **Speech Language Hearing Center**
Be a part of the conversation.™

Audiology Adult History

Name of Patient (Printed) _____ Today's Date _____

What is the reason for your hearing evaluation today? _____

Please list all health conditions you are being treated for: _____

Please list your medications and what health condition they are for: _____

- | | | |
|---|-----------|----------|
| Are you having trouble hearing? | YES _____ | NO _____ |
| Does one ear hear better than the other? | YES _____ | NO _____ |
| Have you ever worn hearing aids? | YES _____ | NO _____ |
| Does anyone in your family have a hearing loss? | YES _____ | NO _____ |
| Have you worked around excessive noise? | YES _____ | NO _____ |
| Have you ever done target practice or gone hunting? | YES _____ | NO _____ |
| Are you having trouble with your memory? | YES _____ | NO _____ |
| Do you smoke cigarettes? | YES _____ | NO _____ |
| Do you have allergies? | YES _____ | NO _____ |
| Have you ever had a stroke or a head injury? | YES _____ | NO _____ |
| Have you ever been seen by an ear specialist (ENT)? | YES _____ | NO _____ |
| Do you have an upcoming appointment with an ENT specialist? | YES _____ | NO _____ |
| Have you had ear surgery? | YES _____ | NO _____ |
| Are you having pain in your ears? | YES _____ | NO _____ |
| Have you had drainage from your ears? | YES _____ | NO _____ |
| Have you been treated for an ear infection? | YES _____ | NO _____ |
| Are you experiencing dizziness? | YES _____ | NO _____ |
| Are you taking blood thinners? | YES _____ | NO _____ |
| Do you have a pacemaker or defibrillator? | YES _____ | NO _____ |
| Do you have ringing, buzzing, or roaring sounds in your ears? | YES _____ | NO _____ |
| Are you involved in a lawsuit concerning your hearing? | YES _____ | NO _____ |

If you answered "YES" to any of the above questions, please explain

