Albuquerque Speech Language Hearing Center

Be a part of the conversation.SM

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:_____

_____

_____

_____

Do you have 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 _____
Do you have 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 _____
Do you have 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.

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