Hunter College Center for Communication Disorder 212.481.4464
425 E 25th St, New York, NY 10033 http://www.hunter.cuny.edu/commdisorders cyscliniz@hunter.cuny.edu

ADULT AUDIOLOGICAL HISTORY

Name _____ Date of Birth _____ / ____ / ____ Age _____

Home Address _____

Email Address: _____

Phone # _____ Cell/Secondary Phone # _____

Emergency Contact: _____ Emergency Contact Phone # _____

Referring Doctor or Primary Care Physician: _____

Insurance Company _____ Insurance #: _____

What is your reason for today's visit? _____

_____

MEDICAL/AUDIOLOGICAL HISTORY

How is your general health? _____

Have you had COVID-19? _____

Please enter any history of diabetes, hypertension or abnormal renal function? _____

_____

What medications are you currently taking? _____

_____

Have you ever taken or been treated with lasix, aminoglycoside antibiotics other ototoxic medications (e.g. cisplatinum, gentamicin sulfate, neomycin sulfate)? _____

_____

History of ear disease or ear surgeries? _____

Recent hospitalizations or surgeries? _____

Family history of hearing loss? _____

History of trauma to the head? _____

Vertigo/dizziness ☐ Yes ☐ No

If you have dizziness, vertigo, or a loss of balance, please describe. Include when it began, the duration, how often it occurs and whether it is accompanied by nausea or vomiting.

_____

_____

Noise Exposure ☐ Yes ☐ No

If you have a history of exposure to noise, please specify what types e.g, military, occupational, recreational, social

_____

_____

Tinnitus/ear ringing ☐Yes ☐No

How do describe the ear noise? _____

Which ear? _____Since when? _____

How frequent?_____What is the duration? _____

Please indicate on the following scale (circle the number) how bothersome the tinnitus is:

1	2	3	4	5
Don't notice	Hardly bothered	Bothered	Very bothered	Terrible

Hearing aids/amplification

Have you ever worn hearing aids? _____

What did you like and/or not like about them?_____

_____

Have you ever used assistive listening devices?_____

HEARING DIFFICULTY QUESTIONNAIRE

Listening Situations	**Hearing Quality**					**Importance to You**		
	Poor				*Normal*	*Not*	*Somewhat*	*Very*
Quiet (one-on-one conversation)	1	2	3	4	5	1	2	3
Television	1	2	3	4	5	1	2	3
Leisure activities	1	2	3	4	5	1	2	3
Restaurants	1	2	3	4	5	1	2	3
Place of worship	1	2	3	4	5	1	2	3
Meetings/groups	1	2	3	4	5	1	2	3
Work place	1	2	3	4	5	1	2	3
Telephone	1	2	3	4	5	1	2	3
Car	1	2	3	4	5	1	2	3
Male voice	1	2	3	4	5	1	2	3
Female voice	1	2	3	4	5	1	2	3
Child's voice	1	2	3	4	5	1	2	3
Other (please indicate in the space below)	1	2	3	4	5	1	2	3

_____ _____

Signature **Date**