HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
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Audiology Case History – NEW PATIENT

Client Name: ______________________________

Date of Birth: _____/_____/________ Today's Date: _____/_____/________

Pronouns: ❑ he/him ❑ she/her ❑ they/them ❑ other: ____________

ARE YOU A VETERAN?
❑ No ❑ Yes

MAIN REASON FOR VISIT

Hearing loss:	Tinnitus (ringing in ears):	Dizziness:
❑ None	❑ None	❑ None
❑ Right ear	❑ Right ear	❑ Spinning
❑ Left ear	❑ Left ear	❑ Unsteadiness
❑ Not sure	❑ Not sure	❑ Nausea
Symptoms started:	Symptoms started:	Symptoms started:
❑ Suddenly	❑ Suddenly	❑ Suddenly
❑ Gradually, _____ years ago	❑ Gradually, _____ years ago	❑ Gradually, _____ years ago

MEDICAL HISTORY

Are you experiencing any of the following?
❑ No ❑ Ear pressure ❑ Ear pain ❑ Ear drainage
Which ear(s): ________ This started: ____________

Do you have a history of ear infections?
❑ No ❑ Yes (when): ____________
❑ Right ❑ Left ❑ Both

Have you ever had a burst / ruptured eardrum?
❑ No
❑ Right ear (when): ____________
❑ Left ear (when): ____________

Have you ever had ear surgery?
❑ No
❑ Right ear (when): ____________
❑ Left ear (when): ____________

Have you had any hazardous noise exposure?
❑ No
❑ Occupational: ____________
❑ With protection ❑ Without protection
❑ Recreational: ____________
❑ With protection ❑ Without protection

Any family history of hearing loss?
❑ No
❑ Yes (check all that apply):
❑ Mother ❑ Father ❑ Sibling
❑ Maternal grandmother / father
❑ Paternal grandmother / father

Have you had any head injuries / TBIs?
❑ No
❑ Yes (when & how): ____________

Have you had any strokes?
❑ No
❑ Yes (when & how): ____________

Do you take blood thinners?
❑ No
❑ Yes

Are you diabetic?
❑ No
❑ Yes

Have you had or do you have cancer?
❑ No
❑ Yes (type & year): ____________
❑ Chemo ❑ Radiation ❑ Surgery

DEVICE HISTORY

Do you wear hearing aids or cochlear implants?
❑ I do not wear any
❑ Hearing aid(s):
❑ Right ear ❑ Left ear ❑ Both ears
❑ Cochlear implant(s):
❑ Right ear ❑ Left ear ❑ Both ears

Are you interested in new devices?
❑ No ❑ Yes (reason): ____________ ❑ Not sure

Are you experiencing any problems with your devices?
❑ I do not wear any
❑ Right: ____________
❑ Left: ____________

ANYTHING ELSE YOU WOULD LIKE THE AUDIOLOGIST TO KNOW