HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
206.323.5770 www.hsdc.org

Audiology Adult History Form

Title: Mr./Ms./Dr./Other_____ Client's Name: _____ Date: _____

Date of Birth: _____ Person completing this form/Relationship: _____

I. Hearing History

1. What specific questions would you like to have answered: _____

   _____

   _____
2. How long have you had trouble hearing? _____
3. Has your hearing become worse in the last year? ☐ Yes ☐ No
4. Which is your better ear? ☐ Right ☐ Left ☐ Same ☐ Unsure
5. Is your hearing better some days than others? ☐ Yes ☐ No
6. Do you have trouble understanding: (*please check*)

   ☐ At home ☐ At work ☐ In noise
   ☐ With one person ☐ In small groups ☐ In crowds
   ☐ On the phone ☐ With radio/TV ☐ At the movies
   ☐ Other: _____
7. Have others brought attention to your hearing loss? ☐ Yes ☐ No
8. Do you feel your hearing has affected your relationships with family, friends, or co-workers?

   ☐ Yes ☐ No

II. Medical History:

1. Have you had your hearing tested before? ☐ Yes ☐ No
   If yes, when? _____ Where? _____
   What were the results? _____
2. Have you had your ears examined by a physician? ☐ Yes ☐ No
   If yes, when? _____ Where? _____
   What were the results? _____
3. Do you know what caused your hearing loss? ☐ Yes ☐ No
   If yes, please explain: _____

   _____
4. Do you suffer from *(please check)*

   ☐ Tinnitus (Ringing) ☐ Dizziness ☐ Ear Pressure ☐ Nausea
   ☐ Ear pain ☐ Ear infections ☐ Ear drainage ☐ Allergies
   ☐ Frequent colds ☐ Other: _____
5. Does anyone in your biological family have a hearing loss? ☐ Yes ☐ No
   Please list: _____

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II. Medical History (*continued*)

6. Have you been treated for any medical problem with your ears? ☐ Yes ☐ No
   Have you had ear surgery? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
7. Have you ever been exposed to high levels of noise? ☐ Yes ☐ No
   ☐ Occupational ☐ Recreational ☐ Other: _____
   Please describe: _____
8. Do you wear ear protection in noise? ☐ Yes ☐ No
9. Have you had any major illnesses? _____
10. Have you experienced head trauma? _____
11. Are you currently taking any medications? ☐ Yes ☐ No
    Please submit a current list of medications. This should be updated at every visit.
12. Do you currently use any tobacco products? ☐ Yes ☐ No

III. Hearing Aid History

1. Do you have hearing aids? ☐ Yes ☐ No Which ears? ☐ Right ☐ Left ☐ Both
2. Make/Model: _____ When were they purchased? _____
3. How long have you worn hearing aids? _____
4. How much do you use your present hearing aid(s)? _____
5. Are your hearing aid(s) helpful for you? ☐ Yes ☐ No
   Describe: _____
6. Describe any problems you may have with your hearing aids: _____
   _____

IV. Special Health Considerations/Precautions

HSDC Staff will review charts and pay special attention to any disclosed healthcare needs (e.g., seizures, pacemaker, diabetes, etc.) Please describe any special precautions or procedures we may need to know in case of emergency:

_____

_____

V. Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ Email: _____