MAICO AUDIOLOGICAL SERVICES

ADULT HISTORY FORM

Name ______________________________ Today's Date ____________________

Date of Birth ____________ Reason for your visit ______________________________

Please answer the following:

Yes No

☐ ☐ Do you **experience hearing loss**? ***Which ear***: ☐ *Right* ☐ *Left* ☐ *Both*

When did you first notice *your hearing loss?* ______________________________

☐ ☐ Have you **had your hearing tested**? ***When***? ______________________________

☐ ☐ Have you **ever worn a hearing aid**? ***Which ear***: ☐ *Right* ☐ *Left* ☐ *Both*

What type? ☐ *In-the-ear* ☐ *Behind-the-ear*

☐ ☐ I would like more information about hearing aids

☐ ☐ Have you **recently been examined by** an otolaryngologist/**Ear, Nose, and Throat physician**?

Physician's Name ____________________ When? ______________________________

Check all that apply:

☐ Developmental disorders/delays ***Please explain***: ______________________________

☐ Dizziness or unsteadiness ***With***: ☐ *Vomiting/Nausea* ☐ *Ear Noises* ☐ *Ear Fullness* ☐ *Falling*

Comments ______________________________

☐ Ear deformity ***Which ear***: ☐ *Right* ☐ *Left* ☐ *Both*

☐ Ear drainage ***Which ear***: ☐ *Right* ☐ *Left* ☐ *Both*

☐ Ear pain ***Which ear***: ☐ *Right* ☐ *Left* ☐ *Both*

☐ Family history of hearing loss ***Who***? ______________________________

☐ History of ear infections ***Which ear***: ☐ *Right* ☐ *Left* ☐ *Both* ***When***? ____________

☐ History of wax buildup ***Which ear***: ☐ *Right* ☐ *Left* ☐ *Both*

☐ History of noise exposure ***Please describe***. ______________________________

☐ Previous ear surgery ***Which ear***: ☐ *Right* ☐ *Left* ☐ *Both* ***When***? ____________

☐ Tinnitus/ringing in ears ***Which ear***: ☐ *Right* ☐ *Left* ☐ *Both*

Is it? ☐ *Constant* ☐ *Comes and goes*

☐ Bell's Palsy ***Which ear***: ☐ *Right* ☐ *Left* ☐ *Both* ***When***? ____________

☐ Have an implanted device ☐ **Pacemaker** ☐ **Defibrillator** ☐ Other

☐ Vision issues **Comment** ______________________________

Check all that apply:

☐ AIDS/HIV
☐ Arthritis/Dexterity issues
☐ Diabetes
☐ Cancer
  ☐ Chemotherapy
  ☐ Radiation
☐ Headaches
☐ Head injury
☐ Measles
☐ High blood pressure
☐ Syphilis
☐ Scarlet fever
☐ Stroke
☐ Mumps
☐ **Smoke cigarettes or use other tobacco products**

Please list your <u>CURRENT MEDICATIONS</u> (over the counter and prescriptions) on the back of this form OR you may provide a copy of your medications list to the receptionist.

Please use the space below to list your medications. When possible, please include how much you take, how often, and how you take it.

Example: Aspirin 81mg once a day orally

Other notes or comments: