Paschall Michaud Gier Robertson

Asheville Head Neck & Ear Surgeons, PA

ADULT AUDIOLOGICAL HISTORY

ID#_____
(For Office Use Only)

Legal Name: _____ _____ _____
First Middle Last

Preferred Name: _____ Date Of Birth: ___/___/___ Age: _____ Sex: M F

Do you think you have a hearing problem? □ Yes □ No □ Not Sure If Yes, which ear? □ Right □ Left

Is there a history of hearing loss in your family? □ Yes □ No □ Not Sure

If yes, which family member(s) have a loss? _____ Cause: _____

Check all that apply:

□ Frequent ear infections
□ Draining ears
□ Ear pain, swelling or tenderness
□ Fullness or pressure in the ears
□ Acoustic trauma (gunfire, firecrackers)
□ Frequent colds, allergies / sinus problems
□ Visual problems
□ Skull trauma / loss of consciousness
□ Head, neck or ear surgery

Please indicate which of the following you have had:

□ Measles
□ Mumps
□ Meningitis
□ Rubella
□ Cerebral Palsy
□ Scarlet Fever
□ Malaria
□ Other / Explain: _____
□ Shingles
□ Speech / language problems
□ Bacterial / fungal infection

Have you had / do you have problems with dizziness? □ Yes □ No □ Not Sure

If yes, please check those that apply:

□ I feel lightheaded
□ I feel sick to my stomach
□ I feel like I'm going to fall
□ I feel off-balance
□ The room is spinning and I'm still
□ I feel like I'm spinning and the room is still
□ Other / Explain _____

When did you start feeling dizzy? _____ Have you consulted a physician? □ Yes □ No

Does any particular body movement cause you dizziness? □ Yes □ No If yes, Please List: _____

Do you have problems with tinnitus (Noise in the ears)? □ Yes □ No □ Not Sure Which ear? □ Right □ Left

Do you have a history of exposure to loud noise? □ Yes □ No □ Not Sure

If yes, please describe the type of noise and how long you were / have been exposed: _____

Do you wear hearing protection? □ Yes □ No

Do you have trouble hearing in any of the following situations:

□ On the telephone
□ Watching television
□ Women's voices
□ Men's voices
□ Children's voices
□ At parties / social groups
□ At work
□ With background noise
□ At religious services
□ At the movies
□ At concerts / theatres

Have you ever, or do you currently wear hearing aids? □ Yes □ No Which ear? □ Left □ Right

Are you / were you satisified with them? □ Yes □ No