Port Jefferson Speech & Hearing

hearing is a moment shared

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American Board of Audiology
BOARD CERTIFIED IN AUDIOLOGY

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Page 1 - Medical/Hearing History

Name: _____ Age: _____

1. List current medictions with dosage: Dosage:

   _____ _____

   _____ _____

   _____ _____

2. Constant Tinnitus: (buzzing, high pitch tones, cricket sounds, etc.)

   If Yes indicate: Yes ☐ No ☐ One Ear ☐ Both Ears ☐

   Describe: _____

3. Gradual hearing loss ☐ Sudden hearing loss ☐

   • Important: If sudden hearing loss please indicate date:_____of onset and any ENT examination, testing or treatment.

4. **Describe your hearing loss by answering the following:**

   Difficulty hearing female voices? . . . . . Yes ☐ No ☐

   Difficulty hearing male voices? . . . . . Yes ☐ No ☐

   Difficulty hearing in background noise? . . . . . Yes ☐ No ☐

   Difficulty hearing soft speech? . . . . . Yes ☐ No ☐

   Difficulty hearing in groups of more than 3 people? . . . . . Yes ☐ No ☐

   People in general seem to mumble? . . . . . Yes ☐ No ☐

   Difficulty hearing on telephone? . . . . . Yes ☐ No ☐

   TV volume is at a high level? . . . . . Yes ☐ No ☐

   Can hear blinker? . . . . . Yes ☐ No ☐

5. Family history of hearing loss? . . . . . Yes ☐ No ☐

   If No please skip to question number question 6.

   Adults younger than 65 years? . . . . . Yes ☐ No ☐

   Describe: _____

   Siblings? . . . . . Yes ☐ No ☐

   Describe: _____

   Children? . . . . . Yes ☐ No ☐

   Describe: _____

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Page 2 - Medical/Hearing History

6. Have you had a hearing test within the last year? . . . . . Yes ☐ No ☐

7. Do you wear hearing aids? . . . . . Yes ☐ No ☐

8. Do you feel you need hearing aids? . . . . . Yes ☐ No ☐

9. Do you have episodes of dizziness? . . . . . Yes ☐ No ☐
   If Yes please answer the following:

   Is the dizziness recent? . . . . . Yes ☐ No ☐

   Have you had dizziness for several weeks, months or years? . . . . . Yes ☐ No ☐

   Describe: _____

   When you get up from lying down? . . . . . Yes ☐ No ☐
   Sudden movement from a head turn? . . . . . Yes ☐ No ☐
   Passenger in car/movements of objects causes dizziness? . . . . . Yes ☐ No ☐

   Describe in detail your dizziness or balance problems: _____

   _____

10. Ear surgery? . . . . . Yes ☐ No ☐

    Explain _____

11. Noise exposure (working in loud environment; exposure to loud machines, firearms, construction equipment, etc) . . . . . Yes ☐ No ☐

    Explain _____