AUDIOMETRIC CASE HISTORY

Name: _____ Gender: ☐ Male ☐ Female
Home Phone: (_____)_____ Cell Phone: (_____)_____
Address: _____
Email Address: _____
Birthdate: _____ Referral Source:_____
Primary Care Physician:_____
Clinic Location:_____
Personal Health Number: *(required only if we are going to access hearing aid benefits on your behalf, from Alberta Aids to Daily Living)*
_____ *(office use only):* ☐ 75% AADL ☐ 100% AADL ref#:_____
WCB or DVA claim # *(if applicable)*:_____

Why are you here?_____
Hearing Loss: ☐ Yes ☐ No ☐ Unsure Which Ear: ☐ Right ☐ Left Better Ear: ☐ Right ☐ Left
Age/Time of Onset:_____
Pertinent health status at onset: _____
Check if Applicable:
☐ Progressive (☐ gradual / ☐ rapid) ☐ Fluctuant ☐ Sudden Onset
☐ Family History of hearing loss prior to age 50
Previous hearing tests: ☐ No ☐ Yes Date: _____
Results: _____
Situations that cause difficulty:_____
Noise exposure: ☐ No ☐ Yes Describe _____
Have you used ear protection: ☐ Yes ☐ No (Describe): _____
Medical History: (check all that apply)
☐ Head injury with unconsciousness (when:_____)
☐ Ear pain (☐ Right ☐ Left ☐ Both) Onset/Describe:_____
☐ Discharge from the ear (☐ Right ☐ Left ☐ Both) Onset/Describe:_____
☐ Fullness or pressure (☐ Right ☐ Left ☐ Both) Onset/Describe: _____
☐ Ear deformity (☐ Right ☐ Left ☐ Both) Onset/Describe: _____
☐ Visible congenital or traumatic deformity of the ear (☐ Right ☐ Left ☐ Both) Onset/Describe: _____
_____
☐ Ear wax accumulation (☐ Right ☐ Left ☐ Both) Onset/Describe: _____
☐ Foreign Body in ear (☐ Right / ☐ Left ☐ Both) Onset/Describe: _____
History of Ear Infections: ☐ Yes ☐ No Ear: ☐ Right ☐ Left ☐ Both Age of Onset:_____
Age of last infection:_____ Treatment: _____
Remarks/Describe:_____

Ear Surgery: ☐ Yes ☐ No Ear: ☐ Right ☐ Left ☐ Both
Type/Date of Surgery: _____
Remarks/Describe:_____

Tinnitus: ☐ Yes ☐ No Ear: ☐ Right ☐ Left ☐ Both ☐ Constant ☐ Fluctuates
Describe: ☐ Hissing ☐ Ringing ☐ Buzzing ☐ Thumping ☐ Clicking ☐ Other:_____
Irritation level: ☐ Mild ☐ Moderate ☐ Moderate-Severe ☐ Severe ☐ Non-Irritating
Tinnitus treatment: ☐ Yes ☐ No Date/Describe: _____
Remarks:_____

Vestibular/Balance History: ☐ Yes ☐ No Vertigo: ☐ Yes ☐ No
Other vestibular symptoms: ☐ Light-Headedness ☐ Spinning sensation ☐ Unsteadiness ☐ Imbalance
Accompanying Symptoms: ☐ Nausea ☐ Change in or onset of tinnitus ☐ fluctuating hearing loss
☐ Fullness or Pressure ☐ Other:_____
Two or more falls in the past year or once with an injury: ☐ Yes ☐ No
Vestibular/Balance Treatment(s):_____
Remarks/Describe:_____

Currently wear hearing aid(s): ☐ No ☐ Yes Tried hearing aids?: ☐ No ☐ Yes
Type: _____ Make/Model: _____ Ear: _____
Purchased/Trialed from: _____
Length of use: (years) _____ Full time use: ☐ No ☐ Yes
Situations where aid(s) most helpful: _____
_____
Additional comments: _____
_____