

AUDIOLOGICAL CASE HISTORY

GENERAL INFORMATION

Name: _____ Occupation: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Referred by: _____

Home Address: _____

Email Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

PURPOSE OF EXAMINATION: _____

CASE HISTORY

Chief complaint: _____

Situations of greatest difficulty: _____

Description of onset and progression of loss: _____

Ear pathology and treatment and/or surgery: _____

Associated physical symptoms, diseases, and disabilities: _____

Drug therapy: _____

TINNITUS:	EARS: Right <input type="checkbox"/> Constant <input type="checkbox"/> Left <input type="checkbox"/> Periodic <input type="checkbox"/>	SEVERITY:	DESCRIBE:
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Vertigo: _____

Noise exposure: _____

Family history of hearing loss: _____

HEARING AID STATUS

MAKE & MODEL:	EAR:	DATE OBTAINED:	EFFECTIVENESS:
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AURAL REHABILITATION

TYPE:	WHERE ATTENDED:	DATE:
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OTHER COMMENTS: _____
