AUDIOLOGY CONCEPTS
Edina | Burnsville | Duluth | Grand Rapids | Superior

New Patient Case History

Patient Name: **Date:**

Chief complaint: ☐ Hearing Loss: ☐ Right Ear ☐ Left Ear ☐ Both Ears ☐ Tinnitus (Ringing) ☐ Dizziness / Balance
How long have you noticed this difficulty? _____

Have you ever been exposed to any of the following (check all that apply): ☐ Other:
☐ Farm Machinery ☐ Power Tools ☐ Loud Music ☐ Gunfire ☐ Military ☐ Factory Noise ☐ Jet Engines

Have you experienced any of the following (check all that apply):
☐ Sudden / Rapid Hearing Loss ☐ Ear Pain ☐ Tinnitus (Ringing) ☐ Ear Drainage ☐ Ear Deformity ☐ N/A

Have you had a hearing test before? ☐ Yes; date of last test: _____ / ☐ No

Have you seen an Ear, Nose and Throat (ENT) Physician? ☐ Yes / ☐ No
If yes, whom: _____ and when:_____

Is there a history of hearing loss in your family? ☐ Yes / ☐ No If yes, whom: _____

Have you had or do you currently have any of the following (check all that apply):

☐ Arthritis	☐ Diabetes	☐ HIV	☐ Parkinson's	☐ Ear Infection: ☐ Child / ☐ Adult
☐ Asthma	☐ Head Injury	☐ Malaria	☐ Scarlet Fever	☐ Cancer: _____
☐ Bell's Palsy	☐ Heart Trouble	☐ Measles / Mumps	☐ Sinusitis	☐ Neurological Symptoms
☐ Dementia	☐ Hepatitis	☐ Meningitis	☐ Stroke / TIA	☐ High Blood Pressure
☐ Visual Disturbances: _____				☐ Visual Troubles-Loss / Sight

If you have used or currently use hearing aids, which ear is or was aided: ☐ Right ☐ Left ☐ Both
How long have you used a hearing aid? _____When were your hearing aids purchased? _____

List 3 situations where you would like to hear better:

1.
2.
3.

If a hearing aid is recommended for you, please rank on a scale of 1-4 how important each of the following is to you: (1 being extremely important and 4 being not very important)

Improved Hearing in Quiet Cosmetic Appearance Improved Hearing in Noise Cost

Have you ever experienced dizziness, unsteadiness, imbalance, or vertigo? ☐ Yes / ☐ No
If yes, do you feel dizzy today? ☐ Yes / ☐ No If yes, describe: _____Frequency:_____

Have you used a tobacco product once or more in the last 24 months? ☐ Yes / ☐ No
If yes, how often and what products: _____

Current Medications (Please list below):

Drugs:	Dosage:	Frequency:	Over the Counter Drugs/ Herbals/Dietary Supplements:	Dosage:	Frequency:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____