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

Returning Patient Case History

Patient Name: **Date of Exam:**

Date of Last Hearing Evaluation:

Approximately, how many hours per day do you wear your hearing devices: _____ / day

Do you think your hearing has changed? ☐ Yes / ☐ No

If yes, which ear: ☐ Right ☐ Left ☐ Both

Over how long: ☐ Sudden ☐ Weeks ☐ Months ☐ Years

Have you had any major medical events since you were last here? ☐ Yes / ☐ No

If yes, what happened and when?

Have you had any falls since you were last here? ☐ Yes / ☐ No

If yes, when? Did you hit your head? Have you recovered?

Have you had any recent medication changes that may have affected your hearing? ☐ Yes / ☐ No

What is your current health status: ☐ Good Health ☐ Cold ☐ Sinus Infection ☐ Allergies ☐ Other:

Ear Pain? ☐ Yes / ☐ No

If yes, which ear: ☐ Right ☐ Left ☐ Both Duration: _____

Ear Drainage? ☐ Yes / ☐ No

If yes, which ear: ☐ Right ☐ Left ☐ Both Duration: _____

Have you seen an ENT? ☐ Yes / ☐ No

Tinnitus (Ringing)? ☐ Yes / ☐ No

If yes, which ear: ☐ Right ☐ Left ☐ Both

Manner: ☐ Constant ☐ Intermittent ☐ Pulsate

Pitch: ☐ High ☐ Low

Has there been any change in your tinnitus? _____

Balance? ☐ Good ☐ Fair ☐ Poor

Do you experience: ☐ Dizziness ☐ Vertigo ☐ N/A

Do you use: ☐ Cane ☐ Walker ☐ Wheelchair ☐ N/A

Are you more sensitive to loud sounds than other people around you/sounds are uncomfortably loud?

☐ Yes / ☐ No

Have you ever been exposed to any of the following (check all that apply):

☐ Farm Machinery ☐ Loud Music ☐ Gunfire ☐ Factory Noise

☐ Power Tools ☐ Military ☐ Jet Engines ☐ Other: