SILVERAUDIOLOGY

AUDIOLOGY ADULT HISTORY

Name of Patient (PRINT): _____ Today's Date: _____

What is the reason for your hearing evaluation today?

_____

Please list all health conditions you are being treated for:

_____

_____

Please list your medications and what health conditions they are for:

_____

_____

_____

YES	NO		LEFT	RIGHT
☐	☐	Do you have trouble hearing?	☐	☐
☐	☐	Does one ear hear better than the other?	☐	☐
☐	☐	Have you ever worn hearing aids?	☐	☐
☐	☐	Does anyone in your family have hearing loss?		
☐	☐	Have you worked around excessive noise?		
☐	☐	Have you ever done target practice or gone hunting?		
☐	☐	Do you have trouble with your memory?		
☐	☐	Do you smoke cigarettes?		
☐	☐	Do you have allergies?		
☐	☐	Have you ever had a stroke or a head injury?		
☐	☐	Have you ever been seen by an ear specialist (ENT)?		

YES	NO		LEFT	RIGHT
☐	☐	Do you have an upcoming appointment with an ENT specialist?		
☐	☐	Have you had ear surgery?	☐	☐
☐	☐	Do you have pain in your ears?	☐	☐
☐	☐	Have you had drainage from your ears?	☐	☐
☐	☐	Have you been treated for an ear infection?	☐	☐
☐	☐	Are you experiencing dizziness?		
☐	☐	Are you taking blood thinners?		
☐	☐	Do you have a pacemaker or defibrillator?		
☐	☐	Do you have ringing, buzzing or roaring sounds in your ears?	☐	☐
☐	☐	Are you involved in a lawsuit concerning your hearing?		

If you answered "YES" to any of the above questions, please explain:

_____

_____

_____

Terri Sankovitz, Au.D.
575.993.9849 · silveraudiology@gmail.com · www.SilverAudiology.com · 1016 Pope St., Silver City, NM 88061