San Diego State University
Audiology Clinic
5550 Campanile Drive
(619) 594-7747

Adult Hearing Information Form

Date of Application:______________________

Name: ____ Date of Birth:_____________

Address: ____ Phone:__________________
(number, street) (city) (zip code)

Work Phone: ___________ Cell Phone: ____________ Email:___________________________________

Is the above applicant a Medicare recipient? ☐ Yes ☐ No

Who referred you to the Audiology Clinic?____

Please indicate any concerns you have. Check all that apply:

☐ Hearing Loss
☐ Difficulty understanding soft speech
☐ Difficulty Understanding in Noise
☐ Difficulty Hearing on the Telephone
☐ Noises in Your Ears………………… ☐ Right ☐ Left ☐ Both
☐ Dizziness
☐ Other…………………… Please specify: ______________________________

Tell us about your hearing

From which ear do you hear better?……. ☐ Right ☐ Left ☐ Unknown
Did your hearing loss come on:………… ☐ Suddenly ☐ Gradually ☐ Unknown
Has it gotten worse over time?…………. Yes ☐ No ☐ Unknown
Does it change from time to time?……… ☐ Yes ☐ No ☐ Unknown
Does anyone in your
family have a hearing loss?……………... ☐ Yes ☐ No ☐ Unknown
Have you ever had a hearing test………. ☐ Yes ☐ No

Have you ever had any exposure to:

Loud Noises?.. ☐ Yes ☐ No ☐ Unknown
Harsh Chemicals or Fumes?.................... ☐ Yes ☐ No ☐ Unknown
Intravenous (IV) Antibiotics?.................... ☐ Yes ☐ No ☐ Unknown

Hearing Aids

Have you ever worn or wear hearing aids? ☐ Yes ☐ No
If yes:
Which ear was/is aided?…………….. ☐ Right ☐ Left ☐ Both
How long have you used hearing aids? _________________
Are you satisfied with the aids? ☐ Yes ☐ No

Medical History

Check any of the illnesses/disorders you have or had in the past:

☐ Cancer ☐ Diabetes ☐ Kidney Problems
☐ Metabolic Disorders ☐ Headaches ☐ Frequent Colds
☐ Ear Wax Build-up ☐ Fullness of Ear ☐ Earaches/Pain
☐ Draining Ear ☐ Blood Pressure Problems

☐ Allergies……………….... Describe:____

☐ Facial Numbness ☐ Numbness of an Arm or Leg

When did the numbness occur? ___________ How long did it last?__________

Please answer the following if you experience dizziness (vertigo):

When was your first episode? ____
How often does this occur? ____
How long does an episode last? ____

Check all that apply

When you were dizzy, did you:
☐ Feel the Room Spin ☐ Have Nausea
☐ Have Double Vision ☐ Fall Down
☐ Have Ringing in your ears
☐ Other: ________________________________

Have you had any injuries to your ears, head, or neck? ☐ Yes ☐ No

If yes, please describe: ____
____

What medical treatment (medicine or surgery) have you received for the conditions noted above? Please include the **name of the physician** and the **dates** of treatment:

____
____

In the space below, please provide any other information you feel we should know:

____
____
____

Would you like SDSU to contact you regarding opportunities to participate in hearing research studies?
☐Yes ☐ No