SDSU College of Health and Human Services
School of Speech, Language, and Hearing Sciences

Audiology Clinic
5500 Campanile Drive
San Diego, CA 92182-1518

Office: 619-594-7747 FAX: 619-594-7109

Adult Hearing Information Form

Name of Patient _____ Date of Birth ___/___/_____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone _____ ☐ okay to text

E-Mail Address _____ ☐ okay to email

Who referred you to our clinic? _____ **Date of Application** _____

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

- ☐ Hearing Loss
- ☐ Dizziness
- ☐ Noises (such as ringing) in your ears..... ☐ Right ☐ Left ☐ Both
- ☐ Other (Please specify): _____
- ☐ Difficulty understanding soft speech
- ☐ Difficulty understanding in noise

Please describe your hearing:

From which ear do you hear better?.....	☐ Right	☐ Left	☐ Unknown/Equal
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	

On a scale from 1 to 10, how would you rate your overall hearing ability? (Please circle)

1	2	3	4	5	6	7	8	9	10
Worst									Best

How important is it for you to improve your hearing right now? (Please circle)

1	2	3	4	5	6	7	8	9	10
Not at all									Very much

Please indicate if you have had exposure to:

- Loud noises?..... ☐ Yes (describe below) ☐ No ☐ Unknown _____
- Harsh chemicals or fumes?..... ☐ Yes (describe below) ☐ No ☐ Unknown _____
- Intravenous (IV) Antibiotics?..... ☐ Yes (describe below) ☐ No ☐ Unknown _____

Please answer the following regarding hearing aids:

Have you ever worn hearing aids? ☐ Yes ☐ No (Please skip this section)

Which ear was/is aided?..... ☐ Right ☐ Left ☐ Both

How long have you been used hearing aids? _____

Are you satisfied with your current aids?..... ☐ Yes ☐ No

Please check any of the illnesses/disorders you currently have or have had in the past:

☐ Cancer ☐ Diabetes ☐ Kidney Problems
☐ Metabolic Disorders ☐ Headaches ☐ Frequent Colds
☐ Blood pressure problems
☐ Allergies; please describe:_____

Please describe any ear related medical history:

Ear wax build-up.....	☐ Right ear	☐ Left ear	☐ Both ears	☐ N/A
Fullness of ear.....	☐ Right ear	☐ Left ear	☐ Both ears	☐ N/A
Drainage in your ear.....	☐ Right ear	☐ Left ear	☐ Both ears	☐ N/A
Earaches/Pain.....	☐ Right ear	☐ Left ear	☐ Both ears	☐ N/A
History of ear infections.....	☐ Right ear	☐ Left ear	☐ Both ears	☐ N/A
Previous ear surgery.....	☐ Right ear	☐ Left ear	☐ Both ears	☐ N/A
Have you seen your physician regarding any of the above?.....			☐ Yes	☐ No

Please describe any numbness:

Have you experienced facial numbness?..... ☐ Yes ☐ No
Have you experienced numbness of an arm or leg?..... ☐ Yes ☐ No
When did it occur? _____
How long did it last? _____

Please describe any dizziness (vertigo):

Have you experienced dizziness (vertigo)? ☐ Yes ☐ No
When was your first episode? _____
How often does it occur? _____
How long does an episode last? _____
When you were dizzy, did you: (check all that apply)

☐ Feel the room spinning ☐ Have nausea
☐ Have double vision ☐ Fall down
☐ Have ringing in your ears
☐ Other: _____

Please describe any injuries to your ears, head, or neck:

Have you had any injuries to your ears, head, or neck? ☐ Yes ☐ No
If yes, please describe: _____
_____

In the space below, please list any medications you have taken in the past 6 months:

_____

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

_____
_____
_____