



Preferred Audiology Services – Partners in Hearing Healthcare

121 Congressional Lane, Suite 310, Rockville, Maryland 20852

(301) 468-0551 (301) 943-3318 (301) 937-0488 fax

Case History

Name: _____

Date: _____

Date of Birth: _____

Age: _____ Sex: _____

Primary Physician: _____

To ensure the best hearing healthcare, please answer the following questions to the best of your knowledge:

- Are you having difficulty hearing/understanding speech? Yes No
If yes, check the listening situations you are having difficulty in:
 meetings group gatherings restaurants
 one-on-one television men's voices
 women's voices children's voices
- How long have you been experiencing difficulty in hearing? _____
- Did your hearing loss come on suddenly or was it gradual? _____
- Do you have tinnitus? Yes No
In which ear? Right Left Both
Is it constant? Yes No
When did you first notice it? _____
Briefly describe your tinnitus: _____

- Do you experience dizziness/vertigo? Yes No
If yes, briefly explain: _____

- Do you have family members who have hearing loss? Yes No
 mother father maternal grandmother
 maternal grandfather paternal grandmother
 paternal grandfather brother sister aunt uncle
 cousin other
- In the past 90 days, you have experienced:
 ear pain R/L drainage from ear(s) R/L
 sudden change in hearing R/L treated by a physician for ear problems

8. Do you have a history of noise exposure? Yes No
 military work recreational seasonal hunting
Did you wear hearing protection during this exposure? Yes No

9. Do you have a history of ear infection or problems that need or needed medical treatment? Yes No
If yes, please briefly explain: _____

10. Do you wear hearing aids? Yes, in my Right ear Left ear
No. of years wearing hearing aid(s) _____
 No

Please briefly state the purpose for today's visit: _____

All information provided by you will be held in confidence. No information will be released without your prior written consent.

Signature

Date

For Audiologist Use: