GARY D. SCHWARTZBERG, Au.D.
Doctor of Audiology

Adult Hearing Health History

Patient Name: _____ Birth Date: _____Date: _____

I. Primary Symptom(s): _____

_____

II. Present Symptoms and Hearing Complaints:

Hearing Loss: Both Ears ☐ Right Only ☐ Left Only ☐ N/A ☐

When did you initially notice your hearing loss? _____

Do you know what may have caused your hearing loss? _____

Has your hearing changed? (i.e. sudden, gradual, fluctuating) _____

Do you have a better hearing ear? _____

Hearing Aids: Both Ears ☐ Right Only ☐ Left Only ☐ N/A ☐

Make: _____ Make: _____

Model: _____ Model: _____

Style: _____ Style: _____

Year fitted: _____ Year fitted: _____

Tinnitus (Noise in ears): Both Ears ☐ Right Only ☐ Left Only ☐ N/A ☐

Describe the sound: _____

When did it first occur? _____

Is it constant or periodic? _____

If periodic, how often does it occur? _____

Is the sound distressing to you? If yes, describe: _____

Feeling of Fullness: Both Ears ☐ Right Only ☐ Left Only ☐ N/A ☐

When did the fullness first occur? _____

Is it constant or periodic? _____

If periodic, how often does it occur? _____

Dizziness or Unsteadiness: N/A ☐

Describe the symptom: _____

When did it first occur? _____

Is it constant or periodic? _____

If periodic, how long does it last? _____

Ear Infections/Middle Ear Problems: Both Ears ☐ Right Only ☐ Left Only ☐ N/A ☐

Describe condition: _____

When did it last occur? _____

Previous treatments: _____

III. In the past 90 days have you experienced:

Ear Pain:	Both Ears ☐	Right Only ☐	Left Only ☐	N/A ☐
Ear Discharge:	Both Ears ☐	Right Only ☐	Left Only ☐	N/A ☐
Sudden Change in Hearing:	Both Ears ☐	Right Only ☐	Left Only ☐	N/A ☐

IV. Have you seen a physician or ear specialist in the last six months? Yes ☐ No ☐

Physicians' Names: _____

_____

V. Medical History:

Ear surgery	Yes ☐	No ☐	Vision loss	Yes ☐	No ☐
Eardrum perforation	Yes ☐	No ☐	Kidney disease	Yes ☐	No ☐
TMJ disorder	Yes ☐	No ☐	Chemotherapy	Yes ☐	No ☐
Head injury	Yes ☐	No ☐	Radiation	Yes ☐	No ☐
Allergies	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Sinusitis	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Meniere's disease	Yes ☐	No ☐	Mumps	Yes ☐	No ☐
Meningitis	Yes ☐	No ☐	Measles	Yes ☐	No ☐
Bell's palsy	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Heart disease	Yes ☐	No ☐	Malaria	Yes ☐	No ☐
High blood pressure	Yes ☐	No ☐	Scarlet Fever	Yes ☐	No ☐
Stroke/TIA	Yes ☐	No ☐	Parkinson's disease	Yes ☐	No ☐
Heart surgery	Yes ☐	No ☐	Alzheimer's disease	Yes ☐	No ☐

VI. Medication Use: (Please include prescription, over-the-counter, herbal and other supplements).

Name	Taken for	Dosage	Frequency	How is it administered

VII. Family History of Hearing Loss:

Relation to you:

1. _____ 3. _____

2. _____ 4. _____

VIII. Noise History:

Do you have military experience? Yes ☐ No ☐

Have you been exposed to loud noise within the past 14 hours? Yes ☐ No ☐

If yes, did you use hearing protection during the entire noise exposure? Yes ☐ No ☐

How often do you use hearing protection when in high noise areas?

0% (Never) ☐ 25% ☐ 50% ☐ 75% ☐ 100% (Always) ☐

Have you ever participated in any of the following?

Firearms	Yes ☐	No ☐	Dirt bike or loud RV	Yes ☐	No ☐
Chain saw	Yes ☐	No ☐	Loud music	Yes ☐	No ☐
Lawn equipment	Yes ☐	No ☐	Other noise exposure:		
Wood working equipment	Yes ☐	No ☐			

IX. Occupational Noise History: (Places of employment where you were exposed to loud noise levels)

Employer	Duties	Length of service	Hearing protection	
1. _____			Yes ☐	No ☐
2. _____			Yes ☐	No ☐
3. _____			Yes ☐	No ☐

X. Social History:

Do you avoid social occasions because you have difficulty hearing? Yes ☐ No ☐

Do you find yourself having to ask people to repeat themselves? Yes ☐ No ☐

Do you sometimes hear words but do not understand? Yes ☐ No ☐

Do you have difficulty understanding people in noisy places? Yes ☐ No ☐

Have you been told that you speak loudly? Yes ☐ No ☐

Do others complain of the television being too loud? Yes ☐ No ☐

Are some voices easier to understand than others? Yes ☐ No ☐

Do you find loud sounds bothersome? Yes ☐ No ☐

Describe your areas of hearing difficulty: _____

_____

Patient Information

Date: _____

Patient Name: _____ Male __ Female __
Last First MI

E-mail Address: _____

Mailing Address: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Birth date: _____ Age: _____ Soc. Sec. #: _____

Work Phone: _____ Employer: _____ Occupation: _____

Referred By: _____

Primary Care Physician: _____

Reason For Visit: _____

Next of Kin: _____ Relationship: _____

Emergency Contact: _____ Phone: _____

Insurance

Primary Insurance Coverage

Insurance Company: _____

Subscriber: _____

Identification #: _____

Group #: _____

Address: _____

Assignment and Release

Please Note: We will be happy to bill your primary insurance carrier. Please forward the appropriate information to your secondary insurance.

Assignment and Release: I hereby authorize Gary D. Schwartzberg, Au.D. to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Gary D. Schwartzberg, Au.D. and acknowledge that I am financially responsible for any unpaid balance.

Signature of Patient or Guardian: _____ Date: _____