Adult Audiological History Form

St. John's University
SPEECH & HEARING CENTER
152-11 Union Turnpike
Flushing, NY 11367
718-990-6480

Mailing Address:
St. John's University
SPEECH & HEARING CENTER
8000 Utopia Parkway
Queens, NY 11439

Name ___________________________ Date ______________ Age ______________________

Address ___________________________ Tel. ___________________________ Cell # ___________________________

City ___________________________ State ___________________________ Zip ___________________________

Occupation: ___________________________ Date of Birth ___________________________

Purpose of referral ___________________________

HEARING LOSS HISTORY

Briefly state chief complaint ___________________________

Date of onset ___________________________ was onset sudden or gradual? ___________________________

Please explain: ___________________________

Was onset related to other health problems and/or hospitalization and/or surgery? ___________________________

Do you have a better ear? ___________________________

Does your hearing fluctuate? ___________________________

Do you have difficulty hearing:

___________ conversation ___________________________ movies ___________________________
___________ soft speech ___________________________ television ___________________________
___________ male voice ___________________________ in quiet surroundings ___________________________
___________ female voice ___________________________ in noisy surroundings ___________________________
___________ telephone/cell phone ___________________________ other ___________________________

AUDIOLOGICAL HISTORY & HABITS

Please answer the following questions YES or NO. If your answer is YES include a brief explanation.

Have you ever had:
Pain in your ears? ___________________________

Discharge from your ears? ___________________________

Impacted cerumen? ___________________________
Adult Audiological History Form

Nausea, dizziness or vertigo?

Tinnitus (ringing, buzzing)? If yes, describe.

Injuries to your head / ear?

Ear Surgery?

Exposure to noise?

GENERAL MEDICAL HISTORY

Have you had any serious illnesses?

Have you been hospitalized? (When and why?)

Are you taking any medication (type)? (Prescription or over the counter)

Do you have any allergies?

Do you have cardiac and / or circulatory problems?

Do you have any endocrine problems or diabetes?

Family history of hearing loss?

REHABILITATION HISTORY

Previous hearing tests? Where and When?

Have you ever worn a hearing aid (type)? How old is your hearing aid?

Are you happy with the performance of your hearing aid(s)?

Have you had lipreading training?

Have you been seen by an ear doctor? Please give name and date:

NAME

DATE

Additional Comments:

All information will be held in strict confidence and not released to any person(s) without explicit authorization to do so, nor will any information be shared with any unauthorized person. The Speech and Hearing Center operates consistent with St. John's University's mission, which prohibits discrimination on the basis of race, religion, color, national or ethnic origin, age, sex, sexual orientation, marital status, or disability. Rev.2/11