NEUROHEAR

Audiological Evaluation Case History Form

Name: ____

Date of Birth: ____

Occupation: ____

1**. Reason** for evaluation:

____
____
____

2. **Suspicions of hearing loss**: Yes/No
   If Yes, which ear: Left/Right/Both

When was the **onset of hearing loss**:

____

3. Do you experience **ringing in your ears/tinnitus**: Yes/No
   If Yes, which ear: Left/Right/Both
   Describe sound:

____
____
____

4. Do you experience any **vertigo or dizziness:** Yes/No
   If Yes, describe situations in which you experience this.

____
____
____

5. Any history of **head trauma**: Yes/No
   If Yes, Explain:

____
____
____

6. Any **family history** of hearing loss: Yes/No
   If Yes, specify if from maternal or paternal side and age onset:

____
____

7. Have you ever had any **ear infections?**

If Yes, which ear: Left/Right/Both

Did you see a doctor and receive a diagnosis or treatment after ear infections?

____
____
____

8. Are you currently taking any **medications**, if so, please list them all including over-the-counter medications:

____
____
____

9. Have you ever got your **hearing tested before**? Yes/No
   If yes, please indicate when, where and what the results indicated:

____
____

10. Have you ever had any of the following **diseases**?

__Mumps	__Scarlet Fever	__Meningitis
__Measles	__Meniere's Disease	__Otitis Media/Ear Infections
__Diabetes	__Cancer	__AIDS/HIV

11. Do you have a history of **noise exposure**? Yes/No
   If yes, please indicate when and where:

____
____
____

12. Have you ever had any **ear surgeries**? Yes/No
   If yes, please explain why

____
____
____

13. Have you ever used **hearing aids or other assistive listening devices**? Yes/No
   If yes, please specify which:

__Hearing Aids __Cochlear Implants __Bone-anchored hearing aids __Other