NORTH CAROLINA AUDIOLOGY ASSOCIATES
Cynthia A. Schaffer, Au.D.

File No ________________

Date __________________

HISTORY INFORMATION

Chief Complaint ____

How Long? ________________________ Progression of Hearing Loss ______________________

Which ear is better? Left _____Right____ Both the same _____

Have you ever had your hearing tested before? Yes _____ No _____If yes, when__________________________

Have you consulted with your physician about your ears? Yes_____ No _____ If yes, explain_______________

____

Have you ever used hearing aids? Yes_____ No _____ How long:___ ________________________________

____

Do you think you need hearing aids? Yes _____ No _____

HEARING HEALTH CONDITIONS:

Please check if you have or have had any of the following conditions.

_____ Ringing or buzzing in your ears
_____ Dizziness
_____ Fullness in your ears
_____ Pain or discomfort in your ears
_____ Ear infections
_____ Drainage from your ears
_____ Noise exposure
_____ Family history of hearing loss
_____ Ear surgery
_____ Deformity of your ears
_____ Sudden or recent onset of hearing loss
_____ Head trauma
_____ Jaw/dental problems
_____ Significant ear wax accumulation

GENERAL HEALTH INFORMATION:

Please check if you have or have had any of the following diseases, medical conditions or procedures.

_____ Arthritis
_____ Cancer
_____ Chemotherapy/Radiation Treatment
_____ Pacemaker
_____ Cardiovascular Disease
_____ Stroke
_____ Diabetes
_____ High Blood Pressure
_____ Blood Thinner
_____ Headaches/Migraines
_____ Hay Fever/Sinus Problems
_____ Glaucoma
_____ Blindness
_____ Macular Degeneration
_____ Neurological Disorders
_____ Anxiety/Depression
_____ Autoimmune Disease
_____ Kidney Problems
_____ Ulcers
_____ Hepatitis
_____ HIV
_____ Memory Loss

Do you have any allergies? Yes _____ No _____ If yes, please list ______________________________________

____

List any other major medical problems____

____

List any medications you may be taking (We can also make a copy of your list) __________________________

____

May we have permission to send your results to your physician? Yes _____No _____ If yes, please list

Physician Name________________________________Address ______________________________

____

Telephone Number ____

Additional Information ____

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