LIFELINE
Audiology & Hearing Solutions, L.L.C
helping you find solutions for all of your hearing concerns

# AUDIOLOGY INTAKE FORM (ADULT)

| Name: | Date: |
|---|---|
| Referring Physician: | Occupation: |

| Reason for today's visit: |
|---|
| |
| |

| Previous Surgeries and Hospitalizations: |
|---|
| |
| |

| Medications (including vitamins, over the counter, herbal, etc.): |
|---|
| |
| |

HISTORY OF:

| | | |
|---|---|---|
| Abnormal renal function (kidney problems) | □ Yes | □ No |
| Hypertension (high blood pressure) | □ Yes | □ No |
| Diabetes | □ Yes | □ No |
| Allergies | □ Yes | □ No |
| Neurological disorder | □ Yes | □ No |
| Migraines | □ Yes | □ No |

Do you feel you have hearing loss? □ Yes □ No

*If yes:*

For how long? _____

In which ear? □ Right □ Left □ Both

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**Prior use of hearing aids?** □ Yes □ No

*If yes:*

When? _____

Which ear? □ Right □ Left □ Both

What kind? _____

Were you satisfied with them? □ Yes □ No

**Have you ever had an ear infection or ear surgery?** □ Yes □ No

*If yes:*

When? _____

Which ear? □ Right □ Left □ Both

**Do you ever experience tinnitus (noises in the ears)?** □ Yes □ No

*If yes:*

For how long? _____

In which ear? □ Right □ Left □ Both

Are the noises constant or intermittent? □ Constant □ Intermittent

Please describe the noise as best you can:

_____

_____

**Do you ever experience dizziness or imbalance?** □ Yes □ No

*If yes:*

When was the onset? _____

How many episodes? _____

Any vomiting/nausea? _____

Please describe the dizziness: _____

**Have you ever been exposed to loud noise?** □ Yes □ No

For how long? _____

Did you wear ear protection? □ Yes □ No

**Have you ever had a head injury?** □ Yes □ No

*If yes:*

Was there any loss of consciousness? □ Yes □ No

**Do you have hearing loss in your family?** □ Yes □ No

*If yes:*

Which family member? _____

Cause of hearing loss (if known)? _____