



## 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) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension (high blood pressure)        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neurological disorder                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Migraines                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> 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)? \_\_\_\_\_