TWIN TIERS
HEARING AID
CLINIC

115 W. Market St. Corning, New York 14830 (607) 973-2458

# Adult Audiology Intake Form

## *Identifying Information*

**Name:** _____
Last First Middle

**Address:** _____
No. & Street City State Zipcode

**Date of Birth:** _____ **Email Address** _____

**Telephone: Home:** _____ **Work:** _____ **Cell:** _____

**Occupation:** _____ **Employer:** _____

**Referred by:** _____ **Marital Status** _____

**Companion/Relative Name:** _____

**May we discuss your care with this person? Yes___, No___. Physicians Name:** _____

**Would you like your results sent to your family doctor? Yes___, No____.**

## *Medical History*

Yes No 1. Do you have difficulty hearing? L___R___B___
Which ear do you hear better with? L____ R____ Same _____
When was the onset of your hearing loss? _____

Yes No 2. Has your hearing loss become progressively worse?

Yes No 3. Have you ever had any ear infections? L_____R_____B_____
When:_____ Physician:_____
Diagnosis:_____ Treatment:_____

Yes___No 4. Have you ever had ear surgery? L_____R_____B_____

Yes No 5. Have you ever had a serious head injury?

Yes___No 6. Have you ever seen a physician for your hearing loss?
When:_____Physician:_____
Diagnosis:_____ Treatment:_____

Yes___No____ 7. Have you ever had your hearing tested before?
When:_____Where:_____
Recommendations:_____

Yes___No____ 8. Does anyone in your immediate family have a hearing loss?
Relative:_____Age:_____
How significant?_____

Yes___No____ 9. Do you hear noises in your ears or head? L____ R____ B____
Since:_____Description:_____
Constantly_____ Intermittently_____

Yes___No____ 10. Do you ever have dizziness?
Since:_____ Description:_____
Constantly_____ Occasionally_____

Yes___No____ 11. Did you ever have any of the following diseases?

| | | |
|---|---|---|
| ____Mumps | ____Scarlet Fever | ____Meningitis |
| ____Measles | ____Meniere's Disease | ____Otits Media |
| ____Diabetes | ____Cancer | ____AIDS |

Yes___No____ 12. Are you currently taking any medication?
_____ For _____

Yes___No____ 13. Do you have a history of noise exposure?
When:_____ Where:_____

Yes___No____ 14. Have you ever worn a hearing aid? L____R____B____
Since:_____Brand:_____Model_____

Yes___No____ 15. Are you satisfied with your hearing aid?

## ***Communication History***

Yes___No____ 1. Do you have any trouble understanding speech in quiet?

Yes___No____ 2. Do you have any trouble understanding speech in noise?

Yes___No____ 3. Do you have any trouble understanding speech on the telephone?

Yes___No____ 4. Is it necessary for you to understand speech on the job?

Yes___No____ 5. Does watching people's lips help you understand speech?

Yes___No____ 6. Do your co-workers state that you have a hearing problem?

Yes___No____ 7. Do you have any trouble understanding speech in large halls?