Audiology
Case History

Name:_____ Date:_____

Reason for Visit_____

_____

_____

List Medications you Take

_____

_____

_____

Do you Experience Any of the following (circle all that apply):

1. Ringing in the ears (tinnitus)
2. Pain in or around the ears (otalgia)
3. Pressure or fullness in the ears
4. Dizziness
5. Family History of hearing loss
6. Difficulty hearing
7. Ear infections

If you circled any of the above, please describe:_____

_____

_____

Have you ever been diagnosed with hearing loss before?

_____

_____

Have you ever worn hearing aids? _____

Are you interested in Hearing Aids? _____

Would you like a report sent to your Dr? If so, who?

_____