Date: 
Patient Name: 
DOB: 

Please provide the following information to the best of your ability:

What problem(s) are you here for today?

________________________________________________________________________________________

1) Please check the “Yes” or “No” box to indicate whether you presently have any of the following symptoms:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear pain</td>
<td></td>
<td></td>
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<tr>
<td>Ear pressure</td>
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<td></td>
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<tr>
<td>Hearing loss</td>
<td></td>
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<tr>
<td>Imbalance</td>
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<tr>
<td>Ear drainage</td>
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<tr>
<td>Tinnitus/Ear noises</td>
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<td></td>
<td></td>
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<tr>
<td>Vertigo (spinning)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

2) For any “Yes” answers, please check the “Current” box if this symptom relates to the reason for your visit today

Have you been exposed to significant noise? (Factory work / guns / military)  □ Yes  □ No  Type/Frequency: ____________________________

Do you have a family history of hearing loss?  □ Yes  □ No  Indicate family member(s): ____________________________

Have you ever had ear surgery?  □ Yes  □ No  Type/ear: ____________________________

1. How old were you when hearing loss was first identified and diagnosed?

_____________________________________________________________________________________

2. What caused your hearing loss?

_____________________________________________________________________________________

3. Which is your better hearing ear?

_____________________________________________________________________________________

4. When did you obtain your first hearing aid(s)?

_____________________________________________________________________________________

5. How old are your current hearing aids?

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
6. Who dispensed your current hearing aids?

__________________________________________________________________________________

7. When was your last hearing aid check up or adjustment?

__________________________________________________________________________________

8. Can you hear well on the phone? If not, when was the last time you heard well on the phone?

__________________________________________________________________________________

9. Which ear do you use on the phone? Has this changed over time?

__________________________________________________________________________________

10. Do you enjoy music? If not, when was the last time you were able to enjoy music?

__________________________________________________________________________________

11. Do you use other assistive listening devices or alerting devices (for TV, phone, smoke detector, wake up alarm, etc)?

__________________________________________________________________________________

12. Do you know anyone who has a cochlear implant?

__________________________________________________________________________________

Would you like a report including today’s test results sent to your physician? Yes ☐ No ☐

If yes, please provide your physician’s name and address or fax number below.

__________________________________________________________________________________

__________________________________________________________________________________

REFERRAL SOURCE: OSU ENT PHYSICIAN ☐ FAMILY PHYSICIAN ☐ FRIEND ☐ FAMILY ☐ ADVERTISEMENT ☐

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