Hackensack
Meridian *Health*
Mountainside Medical Center

Please complete this form and

ADULT HISTORY, AUDIOLOGY

bring it to your hearing test appointment

Patient Name:____ Date of Birth________________________________

Gender: __________________________Referring Physician____

Please describe your problem:____
____
____

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

Which ear? □ Right ear □ Left ear □ Both ears

When did you first notice the problem?____

Medical History

If you have any of the following please check the appropriate box.

□ high blood pressure □ diabetes □ heart disease □ heart attack: When?_______

□ stroke/TIA: When? ______________________ □ cancer/tumor: Where?____________________________

□ seizures □ concussion/head injury: When?_________ □ ear infections

Please list all prior hospitalizations/surgeries: ____
____
____

Please list all medications you are taking including over-the-counter meds: ______________________________________
____
____

Hearing

Is there a family history of hearing loss □ Yes □ No Who? ____

Do you have earaches: □ Yes □ No If yes, when was your last earache? ____________________________________

Do you hear noises in your ears? □ Yes □ No If yes, where? □ right ear □ left ear □ both ears

Please describe the noises : ____

Do you have a history of exposure to loud noise? □ Yes □ No

If yes, where and for how long?____

Did you use a hearing protective device when exposed? □ Yes □ No

ADULT HISTORY PAGE 2

Do you become dizzy? □ Yes □ No

If yes, please describe your dizziness:____

____

Hearing Aid History

Do you currently use a hearing aid? □ Yes □No

If yes, which ear? □ Right □ Left □ Both

What is the make/model of your hearing aids? ____________________

Where did you buy them?____________________________

Pain Assessment

Are you currently in pain? □ Yes □ No Where?____

□If yes, please rate your pain on a scale of 1 to 10 (10 is the most severe pain): ______

Will your pain interfere with taking a hearing test today? □ Yes □ No

Advanced Directive

Do you have an Advanced Directive? □ Yes □ No

If no, would you like information about an Advanced Directive? □ Yes □ No

Fall Risk Assessment

Do you have a history of falls? □ Yes □ No □ *Fall Prevention Guide given*

If yes, when did you last fall?____

Please make a check if you have any of these conditions:

□ Poor vision □ Parkinson's Disease □ Stroke □ Diabetes

□ Confusion □ Alzheimer's Disease □ Heart Disease

Social Assessment

Do you feel safe in your home environment? □ Yes □ No □*Referral to social services*

Are you being hurt or threatened by anyone? □ Yes □ No

Patient signature:____Date_________________________________