Adult Audiology Case History

Kireker Center for Child Development - Valley Hospital
505 Goffle Road Ridgewood, NJ 07450
201-612-1006

Name: _____ Date of Birth: _____ Age: _____

Who recommended this evaluation? _____

Reason for evaluation: _____

Hearing History – *Please indicate if you have experienced any of the following:*

_____ Hearing Loss/Problems: _____ Right Ear _____ Left Ear _____ Both Ears

Better hearing ear: _____ Right Ear _____ Left Ear _____ Equal Hearing

Previous testing completed at: _____

_____ Sudden onset? _____ Ear Infections _____ Fullness in ears

_____ Gradual onset? _____ Exposure to loud noise _____ Head/Neck surgery

_____ Progressive _____ Dizziness/Vertigo _____ Head Injury

Cause: _____ _____ Diabetes _____ Chemotherapy/Radiation

_____ Hearing loss identified at birth _____ Ear ringing/tinnitus ❒ Right Ear ❒ Left Ear ❒ Both Ears

_____ Hearing Aid(s): _____ Right Ear _____ Left Ear _____ Both Ears

Purchased from & when: _____

Which situations are difficult for you because of your hearing loss?

_____ Telephone: ❒ Home ❒ Work ❒ Cell

_____ TV or Radio (at home) _____ Meetings or Conferences

Questionnaire:

	Yes	No	Sometimes		Yes	No	Sometimes
My hearing problem causes me to feel embarrassed when meeting new people.				My hearing problem causes me to have arguments or disagreements with family members or friends.			
My hearing problem causes me difficulty or frustration when visiting with or talking with others.				Listening to the TV, radio or telephone is difficult.			
I have difficulty hearing whispers.				My hearing problem limits or hampers my social life.			
I feel handicapped by my hearing problem.				It is difficult to hear or have a conversation at a restaurant.			
My hearing problem causes me difficulty when trying to hear a conversation in the car							

Additional Information for the audiologist: _____

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