BRC
FAMILY HEARING
SOLUTIONS

Doctors of Audiology
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ADULT HISTORY FORM

Patient Name _____ DOB _____ Today's Date _____

1. What is your main reason for today's visit? _____
2. How did you hear about BRC Family Hearing Solutions? _____
   a. Referral Source: _____
3. Have you experienced any ear infections, either as a child or an adult?
   As a Child: ☐ Yes ☐ No ☐ Right ear ☐ Left ear ☐ Both
   As an Adult: ☐ Yes ☐ No ☐ Right ear ☐ Left ear ☐ Both
4. Have you experienced any pain or discomfort in the last 90 days?
   ☐ Yes ☐ No ☐ If yes, onset date: _____ ☐ Right ear ☐ Left ear ☐ Both
5. Have you experienced any drainage from your ears in the last 90 days?
   ☐ Yes ☐ No ☐ If yes, onset date: _____ ☐ Right ear ☐ Left ear ☐ Both
6. Have you experienced any unexplained dizziness in the last 90 days?
   ☐ Yes ☐ No ☐ If yes, onset date:_____
7. Has there been a sudden decrease in hearing in the last 90 days?
   ☐ Yes ☐ No ☐ If yes, onset date:_____
8. Do you have ringing or noises in your ears?
   ☐ Yes ☐ No ☐ Right ear ☐ Left ear ☐ Both
9. Do you have a history of noise exposure?
   ☐ Yes ☐ No ☐ If yes, occupational _____ Recreational _____
10. Do you wear hearing protection? ☐ Always ☐ Sometimes ☐ Never
11. Have you ever seen an ear, nose and throat (ENT) physician?
    ☐ Yes ☐ No ☐ If yes, who? _____ When? _____ Why? _____
12. Does anyone in your family wear hearing aids?
    ☐ Yes ☐ No ☐ If yes, who? _____
13. Do you currently wear hearing aids?
    ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both How old?_____yrs.
14. Are you interested in the use of hearing aids? ☐ Yes ☐ No
15. Have you had your hearing tested before today?
    ☐ Yes ☐ No By whom? _____
16. What were the recommendations at that time? _____
17. Please list all medications, including prescription, over-the-counter, herbals, vitamin/mineral/dietary supplements, you are currently taking. Please include name, dose and frequency.

_____ _____

_____ _____