Audiology Concepts Edina
6444 Xerxes Ave South
Edina, MN 55423
Phone: 952.831.4222
Fax: 952.831.4942
www.audiologyconcepts.com

New Patient Case History

Patient Name: **Date:**

Chief complaint: ☐ Hearing Loss: Right Ear / Left Ear / Both Ears ☐ Tinnitus (Ringing) ☐ Dizziness / Balance
How long have you noticed this difficulty? _____

Have you ever been exposed to any of the following (check all that apply): ☐ Other:
☐ Farm Machinery ☐ Power Tools ☐ Loud Music ☐ Gunfire ☐ Military ☐ Factory Noise ☐ Jet Engines

Have you experienced any of the following (check all that apply):
☐ Sudden / Rapid Hearing Loss ☐ Ear Pain ☐ Tinnitus (Ringing) ☐ Ear Drainage ☐ Ear Deformity ☐ N/A

Have you had a hearing test before? ☐ Yes; date of last test: _____ / ☐ No

Have you seen an Ear, Nose and Throat (ENT) Physician? ☐ Yes / ☐ No
If yes, whom: _____ and when:_____

Is there a history of hearing loss in your family? ☐ Yes / ☐ No If yes, whom: _____

Have you had or do you currently have any of the following (check all that apply):

☐ Arthritis	☐ Diabetes	☐ HIV	☐ Parkinson's	☐ Ear Infection: ☐ Child / ☐ Adult
☐ Asthma	☐ Head Injury	☐ Malaria	☐ Scarlet Fever	☐ Cancer: _____
☐ Bell's Palsy	☐ Heart Trouble	☐ Measles / Mumps	☐ Sinusitis	☐ Neurological Symptoms
☐ Dementia	☐ Hepatitis	☐ Meningitis	☐ Stroke / TIA	☐ High Blood Pressure
☐ Visual Disturbances: _____				☐ Visual Troubles-Loss / Sight

If you have used or currently use hearing aids, which ear is or was aided: ☐ Right ☐ Left ☐ Both
How long have you used a hearing aid? _____When were your hearing aids purchased? _____

If a hearing aid is recommended for you, please rank the following (1-4) in order of importance to you:
(1 being most important and 4 being least important)

____ Improved Hearing in Quiet ____ Cosmetic Appearance ____ Improved Hearing in Noise ____ Cost

List 3 situations where you would like to hear better:

Have you ever experienced dizziness, unsteadiness, imbalance, or vertigo? ☐ Yes / ☐ No
If yes, do you feel dizzy today? ☐ Yes / ☐ No If yes, describe: _____Frequency:_____

Have you used a tobacco product once or more in the last 24 months? ☐ Yes / ☐ No
If yes, how often and what products: _____

Current Medications (Please list below):

Drugs:	Dosage:	Frequency:	Over the Counter Drugs/ Herbals/Dietary Supplements:	Dosage:	Frequency: