ZN Audiology

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Adult Audiology intake form

Name_____ Date _____ DOB:_____
Referred by:_____Reason for referral_____.
Employed? _____Retired?_____Job Title: _____.

Medical/Hearing History:

Do you consider your health Good_____Fair_____Poor?

List any drugs taken regularly including aspirin_____.

Have you been hospitalized? If so Why?_____.

Any history of High Blood Pressure:____Stroke:___Diabetes:____Voice problems:____.
Seizures;_____Throat problems;____Head Trauma;____Noise exposure;____other:___.

Do you get dizzy or lose your balance_____. If so please describe_____.

Do you experience popping, itching or fullness of the ears?_____.

Do you feel you have a hearing problem?_____.

On a scale of 1 to 10, with 10 being the best, how would you rate your hearing?
Circle number: 1 2 3 4 5 6 7 8 9 10

Have you been exposed to loud sounds? _____ Yes _____ No
Do you have ringing or other noises in your ears or head _____ Yes _____ No
Do you frequently need others to repeat themselves? _____ Yes _____ No
Do you avoid social situations or family gatherings because
you have difficulty hearing in crowds? _____Yes_____No
Can you hear sound but not understand words clearly? _____ Yes _____ No

Have you had your hearing tested before_____If yes where?_____.

List questions you would like to be answered by this evaluation_____.
_____.

Office Use Only:

Hearing Loss _____ No _____ Right _____ Left _____Both
Degree of Loss _____ Mild _____ Moderate _____ Severe _____ Profound
Hearing Aids Recommended? _____ No _____Right _____ Left _____ Both

X _____ X _____ Date :
Zarina Naizam, AuD, CCC-A Patient

Hearing Health Assessment (New Patients)

Does a hearing problem	Always	Sometimes	Never
Make it difficult for you to talk on the phone?	A	S	N
Cause others to complain that you turn up TV too loud?	A	S	N
Cause you difficulty following conversation in a restaurants?	A	S	N
Limit your personal/social life?	A	S	N
Cause you to have to ask people to repeat themselves?	A	S	N
Cause you to have difficulty hearing when you are in the presence of background noise?	A	S	N
Cause you to have difficulty hearing women's or children's voice?	A	S	N
Cause you to hear people speak but fail to understand what they say?	A	S	N
Cause you to feel as though others mumble?	A	S	N
Cause you to feel stressed or tired when listening for long periods of time?	A	S	N

Please provide the top three listening situations where you would like to hear better

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-

Please select your current lifestyle and identify your desired lifestyle (if different from present):

Active lifestyle (a lot of background noise) Casual lifestyle (some background noise)

Current Desired Current Desired

Quite Lifestyle (limited background noise) Very Quiet lifestyle (rare background noise)

Current Desired Current Desired

Notes: