CENTER FOR AUDIOLOGY AND HEARING AIDS

Name: ____

Date of Birth: _________________________________

Today's Date: _________________________________

Case History Questionnaire

(12 Years of Age or Older)

Please check all that apply:

- ☐ Hearing loss
- ☐ Balance problems (e.g., dizziness, vertigo)
- ☐ Tinnitus (e.g. ringing, buzzing, hissing in the ears)
- ☐ Ear fullness
- ☐ Ear pain
- ☐ Ear drainage
- ☐ Family history of hearing loss
- ☐ History of ear infections
- ☐ History of ear surgery
- ☐ History of ear/head trauma
- ☐ History of loud noise exposure
- ☐ History of using hearing aids

Please describe your <u>hearing loss</u> if applicable:

- Which ear? ____
- How long? ____
- When was your last hearing examination? ____

Please describe your <u>tinnitus</u> if applicable:

- Which ear? ____
- How long? ____
- Constant or intermittent? ____
- How long does the tinnitus last once it begins? ____

Please describe your <u>balance problems</u> if applicable:

- How long? ____
- Do you spin towards a particular side? ____
- How long does the balance episode last once it begins? ____

How did you hear about Oswego Health Audiology? ____