SUNY New Paltz
Speech, Language and Hearing Center
1 Hawk Drive, HUM 9B
New Paltz, New York 12561
Telephone: (845) 257-3600

ADULT AUDIOLOGICAL INFORMATION FORM

Please answer the questions as fully and accurately as possible, and bring this form with you to your appointment. All of the information we collect is confidential and is used only by the Speech Language and Hearing Center (SLHC) staff.

Today's date: ________________________________

GENERAL INFORMATION:

Patient's name:____ Birthdate: ______________ Age: ____ Sex: ____

Address: ____

____

Telephone:_______________________________________ Email: ____

Occupation: ____

Primary physician:____ Physician phone: _________________________

Physician address: ____

Name of person filling out this form: ____

Address if different from above: ____

____

AUDIOLOGY

REASON FOR EVALUATION:

Do you have trouble hearing or understanding speech? Yes ______ No ______

IF YES:

Which ear(s)?______________________ For how long? __________

Sudden or gradual?____________________________ Does it fluctuate? _____________________________

What do you believe this problem is related to? ____

____

Do you experience difficulty in any of the following situations:

TV and radio? Yes ______ No ______

Telephone? Yes ______ No ______ Which ear do you use for the phone? Left______ Right ______

Conversation in quiet environment? Yes _____ No _____ Conversation in noisy environment? Yes _____ No _____

Male, female, and or children's voices? Specify: ____

Other situation(s)? Specify: ____

In which situation(s) do you have the greatest difficulty?

____

____

Do you experience noise in the ear (tinnitus)? Yes ______ No ______

If yes, which ear? Left______ Right ______ When did it begin? ____________________________________

Sounds like: ____

Do you experience dizziness? Yes ______ No ______ If yes, when did it begin? _____________________________

Describe: ____

Do you experience ear pain? Yes ___ No ___ Ear pressure? Yes ___ No ___ Excessive ear wax? Yes ___ No ___

Do you experience a feeling of fullness in the ear? Yes ____ No ____ If yes, which ear? Left ______ Right ______

When did it begin? ________________ Describe: ____

Have you been treated by a physician for any of these conditions? Yes ______ No ______

If yes, please describe: ____

____

Do you have a history of noise exposure? Yes ______ No ______

If yes, describe the type and length of exposure: ____

Do you have a family history of hearing loss? Yes ______ No _____ If yes, specify whom: ______________________

Do you have a history of ear infections, ear drainage and/or ear drum perforation? Yes ______ No _____

If yes, describe: ____

____

Have you ever been evaluated by an otolaryngologist (Ear-Nose-Throat doctor)? Yes _____ No _____

If yes, when, and what were the findings:____

____

Have you ever had ear surgery? Yes ______ No _____

If yes, describe when, where and why: ____

____

Please list any serious medical conditions and any medications you are taking:___________________________

____

____

Have you had any previous evaluations performed by an audiologist? Yes ______ No _____

If yes, please describe when, where, and the results: ____

____

Have you ever worn or tried a hearing aid or assistive hearing device? Yes ______ No _____

If yes, when, what type, and which ear:____

____

If yes, were you satisfied? Yes ______ No _____ Describe: _____________________________

____

Where would you like the results of your audiological evaluation to be sent?

____

____

____

____

Authorizing signature:____ **Date**: ______________

Authorizing name (print): ____