NJ Hearing Health Center, Inc.
(732) 458-5050
Adult History Form

PERSONAL HISTORY

Full Name (circle one): Mr. Ms. Mrs. Dr. _____

Home Address: _____ ☐ Male ☐ Female

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

E-Mail Address: _____

What is the best way to reach you? ☐ Home ☐ Phone ☐ Cell Phone ☐ E-mail ☐ Other

Referred by: _____ Family Physician: _____

Reason for Referral: _____

HEARING HISTORY

Who first noticed your hearing problem? _____

When did *you* first notice a hearing problem? _____

Was the onset gradual or sudden? _____

Have you seen a physician for your hearing loss? (circle one) Yes No

Have you ever been exposed to loud noise at work or in your hobbies? (e.g.: guns, power tools, tractors, loud music, etc.): (circle one) Yes No If yes, please explain: _____

_____

Please check any of the following situations where you notice hearing difficulty. ☐ T.V. ☐ Radio

☐ Movies ☐ Place of Worship ☐ At a table with 4-6 people ☐ In noisy restaurant ☐ At a party

MEDICAL HISTORY

General current medical condition: (circle one) Poor Fair Good Excellent

List any operations: _____

List any chronic Illnesses: _____

List all current medications: _____

Have you had or do you still have any of the following: If Yes, please explain

Ear infections	Yes	No	_____
Dizziness	Yes	No	_____
Ringing (noises) in the ears	Yes	No	_____
Diabetes	Yes	No	_____
Autoimmune disease	Yes	No	_____
Fullness/stuffiness in the ears	Yes	No	_____
Nausea	Yes	No	_____
Head trauma	Yes	No	_____
Diagnosis of ear problems/disease	Yes	No	_____

HEARING AID HISTORY

Have you ever worn a hearing aid? _____ Make: _____ Model: _____

When did you first start wearing a hearing aid? _____ How old is your current hearing aid? _____

Have your hearing aids been satisfactory or unsatisfactory and why? _____