Potomac Audiology
One Central Plaza
11300 Rockville Pike Suite 105
Rockville MD 20852
240-477-1010

Adult History Form (Please print)

Today's Date: ___________________

Patient's Name: __________________________________ ☐ **Female** ☐ **Male**

Date of Birth (MM/DD/YYYY): ______/______/_______ **Current Age:** ______

Contact Information:

Telephone (Home) _____________ _____ **Telephone (Cell)** ___________________

Email address: ____

Mailing Address: ____
____
____

Describe the **concerns** you have about your hearing ability:
____

____

Please rate your hearing ability for the following 3 situations:

In a quiet room talking with one or two family members or close friends:

☐1 ☐2 ☐3 ☐4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10

Can't hear at all **Hear about half** **Hear everything**

In a restaurant talking with two or three family members or close friends:

☐1 ☐2 ☐3 ☐4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10

Can't hear at all **Hear about half** **Hear everything**

At a party with music playing and talking with many family/friends/acquaintances:

☐1 ☐2 ☐3 ☐4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10

Can't hear at all **Hear about half** **Hear everything**

Hearing and Balance History

1. Have you had your **hearing tested** previously? ☐ Yes ☐ No ☐ Don't recall
   If Yes, please identify the date of the test and the results (if known):
   ____

2. Does anyone in your **family** have a hearing loss? ☐ Yes ☐ No ☐ Don't know
   If Yes, please explain: ____
   ____

3. Do you currently or have you had a history of **medical problems** with your ears?

Ear Infections	☐ Yes ☐ No ☐ Not sure
Medications for the ears	☐ Yes ☐ No ☐ Not sure
Ear Surgery	☐ Yes ☐ No ☐ Not sure
Surgery of the head and/or neck	☐ Yes ☐ No ☐ Not sure
Fractures of the head or neck	☐ Yes ☐ No ☐ Not sure

   If Yes to any of the above, please explain:
   ____
   ____

4. Have you ever been diagnosed with **brain injury** of any kind following trauma to the head from an accident, fall, etc.? ☐ Yes ☐ No ☐ Not sure

   If Yes, please explain: ____

5. Are you currently or have you been exposed to **hazardous noise** (heavy equipment, guns, playing music, motorcycles, etc.)? ☐ Yes ☐ No ☐ Not sure

   If Yes, please describe: ____

6. Have you or do you currently use **hearing protection** (plugs, muffs, etc.) when exposed to hazardous noise? ☐ Yes ☐ No ☐ Not sure
   If Yes, describe the type used: ____

7. Do you currently use or have you ever **used hearing aids/**other hearing devices?
   ☐ Yes ☐ No If Yes, please describe: ______________________________
   ____

8. Do you currently or have you ever experienced **dizziness,** imbalance or vertigo (spinning)? ☐ Yes ☐ No ☐ Don't know
   If Yes, please explain: ____
   ____

9. Have you **fallen** because of being dizzy or feeling off-balance? ☐ Yes ☐ No
   If Yes, please explain: ____
   ____

10. Have you ever had the **dizziness evaluated** or treated? ☐ Yes ☐ No ☐ N/A
    If Yes, please explain: ____

11. Do you have **ringing or buzzing** or other noises in your ears? ☐ Yes ☐ No
    If Yes, explain: ____

➢ If Yes, please rate your **<u>awareness</u>** of the ear noise during the day:

1 2 3 4 5 6 7 8 9 10

Mildly aware **Moderately aware** **Aware all the time**

➢ If Yes, please rate how **<u>bothered</u>** you are by the ear noise during the day:

1 2 3 4 5 6 7 8 9 10

Mildly bothered **Moderately bothered** **Severely bothered**

Medical History

12. Have you been **diagnosed** with any of the following?

    <u>Diabetes</u> ☐ Yes ☐ No
    If Yes, please describe: ____

    <u>Heart/cardiac condition</u> (including high blood pressure) ☐ Yes ☐ No
    If Yes, please describe: ____

    <u>Depression</u> ☐ Yes ☐ No
    If Yes, please describe: ____

    <u>Skin or other cancer</u> ☐ Yes ☐ No
    If Yes, please describe: ____

    <u>Neurological condition</u> (stroke, dementia, numbness, weakness, etc.)
    ☐ Yes ☐ No
    If Yes, please describe: ____

    <u>Vision problems</u> ☐ Yes ☐ No
    If Yes, please describe: ____

    <u>Do you wear glasses/contacts</u>? ☐ Yes ☐ No

13. Are you taking any medications (prescription, over-the-counter, and/or supplements)?

    ☐ Yes ☐ No

    If Yes, please provide the **name** and **how you take** the medication (oral, injection, suppository, etc.)

    ____________________________ ________________________________
    ____________________________ ________________________________
    ____________________________ ________________________________
    ____________________________ ________________________________
    ____________________________ ________________________________

14. Do you smoke? ☐ Yes ☐ No
    If Yes, please describe (how long? tried to quit? used medications to quit?, etc.):
    ____

15. Any other medical issues or concerns at this time? ☐ Yes ☐ No ☐ Not sure
    If Yes, please describe: ____

Would you like a **copy of our findings** sent to your primary care physician?

☐ Yes ☐ No

If Yes, please provide the name and address:

____

____

____

Insurance Information

Primary Insurance:	Policy Holder: Relationship to patient:
ID Number:	Group Number:
Secondary Insurance:	Policy Holder: Relationship to patient:
ID Number:	Group Number: