WRSD Audiology | Medical History

Willie Ross School for the Deaf
32 Norway Street
Longmeadow, MA 01106
(413) 567-0374

Patient Name: _____ DOB: _____ Date: _____
If you are not the patient filling out form, please state name and relation to patient:
_____

Referred by: _____ **Reason for visit:** _____

1. Previous hearing evaluation: ☐ Yes ☐ No
   Where: _____ When: _____
   Test results and recommendations:_____
   _____

2. Do you have diagnosed hearing loss? ☐ Yes ☐ No
   If yes, specify ear: ☐ Right ☐ Left ☐ Both ears
   If applicable, which ear hears BETTER? ☐ Right ☐ Left
   When did the hearing loss begin/age of onset? _____
   Did the loss occur suddenly or gradually? _____
   Has your hearing loss gotten worse since it was identified? ☐ Yes ☐ No

3. Do you have difficulty in any specific listening situations? ☐ Yes ☐ No
   If YES, check all that apply:
   ☐ Telephone ☐ Women and children's voices ☐ In a group of people
   ☐ One to one conversations ☐ Presence of background noise ☐ TV watching
   ☐ Other (describe):
   _____
   _____

4. Do you have any family members that had hearing loss before the age of 50? ☐ Yes ☐ No
   If yes, please explain the relationship to you? _____

5. Do you have a history of ear pain, drainage, or ear infections? ☐ Yes ☐ No
   If yes, specify ear: ☐ Right ☐ Left ☐ Both ears
   When did this occur (approximate date)? _____
   How was it treated?_____

6. Do you have a history of dizziness or vertigo (sensation of room spinning?) ☐ Yes ☐ No
7. Do you hear ringing, buzzing or other head noises? ☐ Yes ☐ No
   If yes, please describe if it is *tolerable* or *bothersome*, and if it is *constant or intermittent*:
   _____

8. Do you get easily bothered by loud sounds? ☐ Yes ☐ No
   If yes, please explain: _____

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9. Do you have a history of ear surgery? ☐ Yes ☐ No
   If yes, which ear? ☐ Right ☐ Left ☐ Both ears
   Date(s) of surgery: _____
   What type(s) of surgery? _____

10. Do you have a history of head trauma? ☐ Yes ☐ No
    (i.e., skull fracture, concussion, unconsciousness)
    If yes, please describe and specify dates and circumstances: _____
    _____

11. Do you have a history of other health conditions? ☐ Yes ☐ No
    (i.e., diabetes, cancer, stroke, heart disease, meningitis, kidney problems, headaches)
    If yes, please describe and state if condition was present at birth or later acquired in life:
    _____
    _____

12. Do you currently take any prescribed medications? ☐ Yes ☐ No
    If yes, please list medications below (name, description, dosage and route):
    _____
    _____

13. Do you have any allergies (*i.e., silicone, latex, acrylic, metal*) ☐ Yes ☐ No
    If yes, please list below:
    _____
    _____

14. Do you have a history of noise exposure? ☐ Yes ☐ No
    (i.e., recreation, work, armed forces)
    If yes, please list and described where it occurred: _____
    How many years were you exposed to noise? _____
    Was hearing protection worn? _____

15. Have you ever worn or trialed hearing devices? ☐ Yes ☐ No
    If yes, which style *(i.e., behind the ear, in the ear, bone anchored hearing device):* _____
    Ear fitted: ☐ Right ear ☐ Left ear ☐ Both ears
    Where were the aids purchased and fit? _____
    Length of time worn (every day or infrequently): _____
    Benefits/Limitations/Additional comments:_____

16. Please describe any hearing concerns related to communicating with family, language development, work, daily activities, or social involvement, if applicable.
    _____