

ZN Audiology

Your better hearing is our goal

1389 E 18 Street
Brooklyn, NY 11230

12-15 72 Road Forest
Hill, NY 11375

Adult Audiology Intake Form

Name

Date

Occupation

DOB

Referred By:

Reason for Referral

MEDICAL/HEARING HISTORY

1. Do you consider your health ◯ Good ◯ Fair ◯ Poor
2. List any drugs taken regularly, including aspirin
3. Have you been hospitalized? ◯ Yes ◯ No

   If Yes, Why?
4. Any history of ◯ High Blood Pressure ◯ Stroke ◯ Diabetes

   ◯ Voice Problems ◯ Seizures ◯ Throat Problems ◯ Head Trauma

   ◯ Noise Exposure Other
5. Do you get dizzy or lose your balance ◯ Yes ◯ No

   If Yes, please describe
6. Do you experience popping, itching or fullness of the ears? ◯ Yes ◯ No
7. Do you feel you have a hearing problem? ◯ Yes ◯ No
8. On a scale of 1 to 10, with 10 being the best, how would you rate your hearing?

   ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

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Adult Audiology Intake Form - Continued

MEDICAL/HEARING HISTORY		Yes	No
9.	Have you been exposed to loud sounds?	◯	◯
10.	Do you have ringing or other noises in your ears or head?	◯	◯
11.	Do you frequently need others to repeat themselves?	◯	◯
12.	Do you avoid social situations or family gatherings because you have difficulty hearing in crowds?	◯	◯
13.	Can you hear sound but not understand words clearly?	◯	◯

14. Have you had your hearing tested before? ◯ Yes ◯ No

If Yes, Where? _____

15. List questions you would like to be answered by this evaluation

_____

OFFICIAL USE ONLY:

Hearing Loss?	◯ No	◯ Right	◯ Left	◯ Both
Degree of Loss?	◯ Mild	◯ Moderate	◯ Severe	◯ Profound
Hearing Aids Recommended?	◯ No	◯ Right	◯ Left	◯ Both

I am aware that it is my duty to submit truthful information.

◯ **I agree to the terms of service**

× _____ Audiologist

× _____ Patient

Date: _____

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Hearing Health Assessment

DOES A HEARING PROBLEM:	Always	Sometimes	Never
Make if difficult for you to talk on the phone?	◯	◯	◯
Cause others to complain that you turn up TV too loud?	◯	◯	◯
Cause you difficulty following conversations in a resturant?	◯	◯	◯
Limit your personal/social life?	◯	◯	◯
Cause you to have to ask people to repeat themselves?	◯	◯	◯
Cause you to have difficulty hearing when you are in the presence of background noise?	◯	◯	◯
Cause you to have difficulty hearing women's or children's voices?	◯	◯	◯
Cause you to hear people speak but fail to understand what they say?	◯	◯	◯
Cause you to feel as though others mumble?	◯	◯	◯
Cause you to feel stressed or tired when listening for long periods of time?	◯	◯	◯

Please provide the top three listening situations where you would like to hear better

Please select your current lifestyle and identify your desired lifestyle (if different from present):

Active Lifestyle (a lot of background noise)	◯ Current	◯ Desired
Casual Lifestyle (some background noise)	◯ Current	◯ Desired
Quiet Lifestyle (limited background noise)	◯ Current	◯ Desired
Very Quiet Lifestyle (rare background noise)	◯ Current	◯ Desired

Is there anything else you would like to make us aware of?

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