



# Weill Cornell Medicine

## Otolaryngology

### Head & Neck Surgery

#### AUDIOLOGY INTAKE FORM (ADULT)

Name:	Date:
Referring Physician:	Occupation:

Reason for today's visit:

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Previous Surgeries and Hospitalizations:

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Medications (including vitamins, over the counter, herbal, etc.):

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**HISTORY OF:**

- Abnormal renal function (kidney problems)  Yes  No
- Hypertension (high blood pressure)  Yes  No
- Diabetes  Yes  No
- Allergies  Yes  No
- Neurological disorder  Yes  No
- Migraines  Yes  No

Do you feel you have hearing loss?  Yes  No

*If yes:*

For how long? \_\_\_\_\_

In which ear?  Right  Left  Both

**Prior use of hearing aids?**  Yes  No

*If yes:*

When? \_\_\_\_\_

Which ear?  Right  Left  Both

What kind? \_\_\_\_\_

Were you satisfied with them?  Yes  No

**Have you ever had an ear infection or ear surgery?**  Yes  No

*If yes:*

When? \_\_\_\_\_

Which ear?  Right  Left  Both

**Do you ever experience tinnitus (noises in the ears)?**  Yes  No

*If yes:*

For how long? \_\_\_\_\_

In which ear?  Right  Left  Both

Are the noises constant or intermittent?  Constant  Intermittent

Please describe the noise as best you can:

\_\_\_\_\_  
\_\_\_\_\_

**Do you ever experience dizziness or imbalance?**  Yes  No

*If yes:*

When was the onset? \_\_\_\_\_

How many episodes? \_\_\_\_\_

Any vomiting/nausea? \_\_\_\_\_

Please describe the dizziness: \_\_\_\_\_

**Have you ever been exposed to loud noise?**  Yes  No

For how long? \_\_\_\_\_

Did you wear ear protection?  Yes  No

**Have you ever had a head injury?**  Yes  No

*If yes:*

Was there any loss of consciousness?  Yes  No

**Do you have hearing loss in your family?**  Yes  No

*If yes:*

Which family member? \_\_\_\_\_

Cause of hearing loss (if known)? \_\_\_\_\_