Georgian

Georgian College Harmonize for Speech, Hearing and Language Clinic

1 Georgian Drive, Room M233 Barrie, ON L4M 3X9
Phone: (705) 722-1561 Fax: (705) 722-1562 Email: H4SHLclinic@georgiancollege.ca

Audiology Adult History

Today's Date (mm/dd/yyyy): _____

Patient Name: _____

Date of Birth (mm/dd/yyyy): _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ Postal Code: _____ Business Phone: _____

Email: _____

Family Physician: _____

Address / City of Physician: _____

What is your reason(s) for seeking care at our clinic, and what do you hope to gain from the care?

_____

Did anyone refer you to our clinic? If yes, who? _____

1. Do you have problems hearing?

☐ No ☐ Yes, right ear only ☐ Yes, left ear only ☐ Yes, both ears

If yes, was your hearing loss: ☐ Gradual OR ☐ Sudden

2. Is your hearing the same in both ears?

☐ Yes ☐ No, right is worse ☐ No, left is worse ☐ Unsure

3. Have you had any dizziness lately?

☐ No ☐ Yes

4. Do you have any noises in your ears (ex. ringing or hissing)?

☐ No ☐ Yes, right ear only ☐ Yes, left ear only ☐ Yes, both ears

If yes, please describe: _____

If yes, is it: ☐ Constant OR ☐ Intermittent

5. Do other people in your family have hearing problems?

☐ No ☐ Yes ☐ Unknown / Unsure

If yes, please describe who and type of problem: _____

6. Have you had surgery on your ear(s)?

☐ No ☐ Yes, right ear only ☐ Yes, left ear only ☐ Yes, both ears

If yes, please detail surgery and approximate date/age:

_____

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7. Did / Do you work in a noisy place?

☐ No ☐ Yes

If yes, please describe how long you have/did work there: _____

8. Are you covered by any of the following for Audiology Assessments and/or Hearing Tests?

☐ Veterans Affairs Canada (VAC) ☐ Workplace Safety and Insurance Board (WSIB) ☐ Unsure ☐ No

9. Have you had any other significant noise exposure (non-work related)?

☐ No ☐ Yes

If yes, please describe: _____

10. Have you ever had a hearing aid?

☐ No ☐ Yes, right ear only ☐ Yes, left ear only ☐ Yes, both ears

If yes, how old is/are your hearing aid(s)? _____

11. Have you ever been seen by an Ear, Nose and Throat (ENT) physician?

☐ No ☐ Yes

If yes, who and when? _____

12. Please list any allergies you have (medications, food, environmental, latex/rubber, etc.), including the reaction/severity you have to the allergen:

☐ **None**

If you have allergies, do you carry an EpiPen? ☐ No ☐ Yes

13. Are you taking blood thinners (including regular Aspirin)?

☐ No ☐ Yes ☐ Unsure

14. Do you have a pacemaker?

☐ No ☐ Yes

Other Comments / Questions / Concerns