Medical Record #: ____________________

Hackensack Meridian *Health*
Joseph M. Sanzari Children's Hospital

Audiology Department
(551) 996-5327

ADULT QUESTIONNAIRE

PATIENT INFORMATION

Patient's Name: ____

Date of Birth: ____________________ Date(s) of Evaluation: ____________________

________________________________ ________________________________
Signature of Patient/Parent/Guardian *Relationship to Patient*

PREFERRED PROVIDER INFORMATION

Check box if you would like us to send results to your provider

Primary Care Physician/Pediatrician: Address: City/State/Zip: Phone Number: Fax Number:	☐
ENT/Otolaryngologist: Address: City/State/Zip: Phone Number: Fax Number:	☐
Hearing Aid Dispenser: Address: City/State/Zip: Phone Number: Fax Number:	☐
Other: Address: City/State/Zip: Phone Number: Fax Number:	☐

PATIENT INFORMATION

First, Middle, Last Name: ____

Date of Birth: ___________________ Age: ____________ Gender (circle): Male Female

Address: ____

City: ____________________________ State: _____ Zip: __________ County: ____________

Phone Number: _____________________ Email: ____________________________

Primary Language: ________________________

Primary concern for this appointment: ______________________________________

Who referred you for this appointment? ______________________________________

AUDIOLOGICAL HISTORY

Do you have a problem hearing? NO YES

When did you first notice it? ______________________________________

Do you hear better in one ear? NO YES If yes, which ear? _______________________

Was the loss: ☐ Sudden ☐ Gradual Please explain: ______________________________

Do you know what caused the hearing loss? ______________________________

Does your hearing ever seem to change? NO YES

Please explain: ____

Do you get ear infections? NO YES

Do you ever have fullness in your ears? NO YES

Do you have a history of exposure to loud noise? NO YES

If yes, please explain: ____

Do you have tinnitus (ringing in the ears)? NO YES

Describe the tinnitus: ____

Do you have vertigo (dizziness)? NO YES

Describe the dizziness: ____

Any nausea or vomiting? NO YES

Is there any family history of hearing loss? (Include age of onset and cause, if known) NO YES

Please explain: ____

Do you have any related medical history? NO YES

(E.g. Meningitis, pneumonia, head injury, diabetes, heart condition, etc.)

Please explain: ____

Have you ever had head, neck, or ear surgery? NO YES

Please describe: (Include dates) ____

Patient Name: ______________________________

Medical Record #: ____________________

Have you ever taken streptomycin, gentamycin, platinol (a Chemotherapy drug) or any other drug that you were told might affect your hearing? NO YES

Please explain: ____

Please list medications taken regularly: ____

____

Are you currently being treated for an emotional/behavioral illness, depression or substance abuse?

____

Have you had any *recent* changes in your functioning or behavior? NO YES

Have you felt down, depressed, or *hopeless* in the past month? NO YES

HEARING AID INFORMATION

Have you ever owned hearing aids? NO YES

Do you currently wear hearing aids? NO YES

For how long? ____________________

Which ear did you use the hearing aid(s) on? ☐ Right ☐ Left ☐ Both

What type of hearing aid(s) have you used? (Behind the ear, in the ear, etc.) ________________

Where did you obtain the hearing aid(s)? ____

Did you find the hearing aid(s) helpful? NO YES

In which situations were the hearing aid(s) most successful? ________________________________

ADDITIONAL COMMENTS: ____

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