Audiology Case History Form

ARNOLD HEARING CENTRES

Name: _____ DOB DD/MM/YYYY: _____

Current/previous occupation: _____ Date: _____

Reason for appointment: _____

Funding: ☐ ODSP ☐ WSIB ☐ Veterans Affairs ☐ Greenshield

Claim Number for Funding: _____

Has your hearing been tested before?:	☐ Yes	☐ No	If yes, when: _____
Do you think you have hearing loss?:	☐ Left Ear	☐ Right Ear	
Family history of hearing loss:	☐ Yes	☐ No	If yes, who: _____
History of noise exposure:	☐ Yes	☐ No	
If yes:	☐ Workplace	☐ Firearms	☐ Music/Concerts
Tinnitus (hearing ringing/buzzing/etc):	☐ Left Ear	☐ Right Ear	
If present, is the noise:	☐ Mild	☐ Moderate	☐ Servere ☐ Constant
Ear pressure/pain/fullness:	☐ Left Ear	☐ Right Ear	If yes, how long?: _____
History of ear surgery:	☐ Yes	☐ No	If yes, when?: _____
If yes, which ear?:	☐ Left Ear	☐ Right Ear	☐ Both Ears
Have you seen an Ear, Nose and Throat (ENT) Specialist?:	☐ Yes	☐ No	

If yes, please explain: _____

Medical History - check all that apply:

☐ Arthritis	☐ Heart complications	☐ Measles	☐ Blood disorders
☐ High blood pressure	☐ Meningitis	☐ Cancer	☐ Head injury/concussions
☐ Multiple Sclerosis	☐ Diabetes	☐ Cognitive impairment	☐ Stroke
☐ Facial numbness	☐ Mobility impairment	☐ Visual impairment	☐ Dizziness/Vertigo

Medications Related to the Above Conditions: _____