GILMORE AUDIOLOGY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Person filling out this form: □ Self □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL PROBLEMS: (check if you have or ever had that problems) **□ No Medical Problems**

□ Allergies/Hay fever

□ Alzheimer’s/Dementia

□ Arthritis

□ Auto-immune Disease

□ Balance Problem

□ Bleeding Disorder

□ Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Dentures

□ Diabetes

□ Hearing Loss

□ Heart Attack (MI)

□ Heart Disease

□ Hepatitis

□ Hypertension

□ Stroke

□ TMJ

□ Vision Problems

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use a wheelchair? □ Yes □ No If, yes, can you walk a few steps without it? □ Yes □ No

Do you have difficulty: □ Concentrating, remembering or making decisions? □ Dressing or bathing?

□ Doing errands on your own? □ Walking or climbing stairs?

FAMILY HISTORY: Please list who in your family has the following (ex.: mom, son, sister, grandparent):

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□ Allergies/Hay fever\_\_\_\_\_\_\_\_\_\_

□ Alzheimer’s/Dementia \_\_\_\_\_\_\_\_

□ Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Auto-immune Disease \_\_\_\_\_\_\_\_

□ Balance Problem \_\_\_\_\_\_\_\_\_\_\_\_

□ Bleeding Disorder \_\_\_\_\_\_\_\_\_\_\_

□ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Hearing Loss \_\_\_\_\_\_\_\_\_\_\_\_\_

□ Heart Attack (MI) \_\_\_\_\_\_\_\_\_

□ Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_

□ Hepatitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Hypertension \_\_\_\_\_\_\_\_\_\_\_

□ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ TMJ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Vision Problems \_\_\_\_\_\_\_\_\_

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Adopted/Unknown**

SURGERIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Include dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Names & OTCs) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

SOCIAL HISTORY: □ Never Married □ Married □ Divorced □ Separated □ Widowed □ Domestic Partner

Children (sex & age) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ who do you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_

Housing □ Own □ Rent □ Nursing Home/Assisted Living

Caffeine Intake □ None □ Occasional □ Moderate □ Heavy

Alcohol □ None □ Occasional □ Moderate □ Heavy □ Quit \_\_\_\_\_\_\_\_ (Date)

Tobacco □ Never smoked □ Quit \_\_\_\_\_\_\_\_\_\_\_\_ (Date) □ Smoke now How Many Years: \_\_\_\_\_\_ □ Cigarettes \_\_\_\_\_Packs Per Day □ Cigars/Pipe\_\_\_\_\_\_\_ □ Chew/Snuff

Employment: □ FT □ PT □ Retired □ Unemployed □ Disabled □ Stay-home parent □ Student □ Veteran

Current Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ History of Noise Exposure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Use of Hearing Protection?

ALLERGIES and Reactions to Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GILMORE AUDIOLOGY

Do you think you have: Normal hearing a slight loss a significant loss a selective loss

If so, which ear? Right Left Both Is it: Gradual Fluctuating Sudden

Have you ever had your hearing tested? Yes No When? \_\_\_\_\_\_\_\_ Results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1 to 10, 1 being the worst & 10 the best, how would you rate your overall hearing? \_\_\_\_\_\_

Check which statement(s) best describes you:

I think I hear fine.

I only have trouble with the TV.

I only have difficulty hearing on the telephone. I use my *Right Left Both* ear(s) on the phone.

I think I hear fine but other people think I have a hearing loss. Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I think I would hear fine if people spoke (circle appropriate words) *louder slower clearer*.

I hear fine in quiet, I only have trouble in noise (circle) *10% 25% 50% 75% 90%* of the time.

I can hear, I just don’t understand what people are saying (circle) *10% 25% 50% 75% 90%* of the time.

I know I have a hearing loss but it isn’t a problem. I am only here because \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I know I have a hearing loss and I am ready to do something because I’m tired of smiling and nodding.

I have (had) hearing aids but they never seemed to work.

I have (had) hearing aids and they work(ed) but I want to see if newer technology would help me more.

None of these describe me. I will tell you why I made the appointment when I see you.

Do you experience any of the following?

Dizziness/Vertigo/Imbalance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ringing/buzzing/roaring: *Right Left Both* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Excessive ear wax: *Right Left Both* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain in your ears: *Right Left Both* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sudden hearing loss in the past 90 days: *Right Left Both* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drainage from your ears in the past 90 days: *Right Left Both* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ear Surgery: *Right Left Both* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a doctor for any of the above issues? *Yes No Describe*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever worn or tried a hearing aid(s)? *Yes No* Which Ear? *Right Left Both*

When did you get a hearing aid(s)? \_\_\_\_\_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that all of the information on this page and the reverse side are correct to the best of my knowledge.

Signed: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_