Matthew D. Romsey, Au.D., CCC –A
Kendra Neugebauer,Au.D., CCC-A

Avera Professional Office Pavilion 409 Summit St, Suite 2800 Yankton, SD 57078
(605) 655-1220

AUDIOLOGY CASE HISTORY

Patient Name:_______________________________ Date of Birth:__________ Date:____________

Physician/Referral:_________________________ Family Doctor: ___________________________

Please <u>complete</u> fully and <u>check</u> all that apply to you. Thank you!

❑ Hearing Loss ❑ Ear Pain ❑ Pressure/Fullness ❑Ringing/Tinnitus ❑ Noise Exposure ❑ Ear Drainage or Bleeding

❑ Dizziness/Imbalance -- ❑ Surface Dependant ❑ Light Dependant ❑ Constant ❑ Intermittent

Comments: ____

____

____

❑ Head Injuries ❑ Strokes ❑ Heart Attack ❑ Heart Problems ❑ Allergies ❑ Headaches/Migraines

❑ High Blood Pressure ❑ High Cholesterol ❑ Family Hearing Problems ❑Facial Weakness

Comments: ____

<u>List</u> Medications: ____

How would you rate your hearing? **0** **1** **2** **3** **4** **5** **6** **7** 8 **9** **10**

No Hearing 50% Perfect Hearing

Mark all areas where hearing is difficult:

❑Telephone ❑TV/Movies ❑One on One Conversation ❑Small Groups ❑Restaurants ❑ Meetings

❑ Church ❑In the Car ❑ Family Gatherings ❑ Social Events (Coffee, Club Meetings) ❑Outdoors

What situations would you most like to see improved?_______________________________________

____

<u>Office Use Only:</u>

Tympanometery	Jerger Class	Volume	Compliance	Peak Pressure
Left				
Right				

SAC	
SOAC	
SIN	

	Current Aids
Right	
Left	

Comments: ____

____

____

____

____