SWEDISH
MEDICAL GROUP

Swedish Otolaryngology – Audiology

☐ First Hill Office
600 Broadway, Suite 230
Seattle, WA 98122
(t) 206 215 1770
(f) 206 215 1771

☐ Ballard Office
1801 N.W. Market St., Suite 411
Seattle, WA 98107
(t) 206 781 6072
(f) 206 781 6073

☐ Issaquah Office
751 N.E. Blakely Dr., 5th Fl
Issaquah, WA 98029
(t) 425 313 7089
(f) 425 313 7184

AUDIOLOGY INTAKE FORM

Name: _____ **DOB:** _____

I. Main Concern:

II. Additional Symptoms

Do you experience any of the following ear-related symptoms?

Hearing loss	□ yes □ no	which ear?	□ right □ left	better ear?_____
Tinnitus/ear noise	□ yes □ no	which ear?	□ right □ left	
	If yes, describe tinnitus_____			
Ear pain	□ yes □ no	which ear?	□ right □ left	
Ear fullness/pressure	□ yes □ no	which ear?	□ right □ left	
Sensitivity to sound	□ yes □ no	which ear?	□ right □ left	
Dizziness	□ yes □ no	Describe:		
Light-headedness	□ yes □ no	Describe:		
History of noise exposure	□ yes □ no	Describe:		

Other (describe): _____

General Health Status/Chronic Health Conditions

Please describe your general health (poor, fair, good, excellent): _____

Do you/have you experienced the following? ☐ I have not experienced any of the below

Hypertension	□ yes □ no	Cardiovascular disease	□ yes □ no
Diabetes	□ yes □ no	Cancer	□ yes □ no

Any other chronic conditions? _____

Comments:

III. Current Medications/Herbal Supplements

List all medications / reason / duration of use (Only required if new patient to Swedish)

_____
_____
_____

IV. Family History

Do you have a family history of ear-related or balance-related problems? □ yes □ no

If yes, please describe the issue and relationship to you.

Issue:	Relationship:
_____	_____
_____	_____
_____	_____

V. History of Otologic Trauma / Surgery or Illness

Have you experienced any of the following? If so, please indicate details (type, ear, date of event.)

Ear trauma (perforated eardrum) □ yes □ no_____

Cancer treatment (radiation; chemotherapy) □ yes □ no_____

Head trauma □ yes □ no_____

Ear surgery □ yes □ no_____

Recent flying, scuba diving or boating □ yes □ no_____

Recent cough, cold or ear infection □ yes □ no_____

Additional Notes:

VI. Hearing Aid History

Do you wear hearing aids? □ yes □ no which ear? □ right □ left

When did you receive current hearing aids?_____

Describe satisfaction / hearing aid use_____

_____