North Alabama Audiology

BASELINE CASE HISTORY DATE____/____/_____

Mrs.__Ms__Mr__Dr__ _____ _____ _____
First Middle Last

_____ _____/____/_____ How did you hear about us?_____
Preferred name or nickname Birthday

_____
Address City Zip

_____ _____ _____ _____
Mobile phone Home Work Email

_____
Emergency contact Name/phone/relationship

Accompanied by spouse___friend___caregiver___daughter___son___grandchild___parent___(please list names)_____

When did you first notice you were not hearing quite as well as you use to?_____

Describe the top three specific listening environments, situations or persons and list difficulty
(a) always (b) generally (c) almost half (d) occasional (e) none

1. _____
2. _____
3. _____

In which ear is your hearing most impaired? Left___Right___Same___

Which ear do you listen with on the phone? Left___Right___Both___ Bluetooth___Speaker___

In the past 90 days has your hearing-remained fairly Stable___Fluctuated___

Have you noticed greater sensitivity to certain sounds or loud sounds. Please list_____
_____

List noise you may hear in your ear(s) or head especially in a quiet environment_____
Is it occasional___frequent___constant___ Do you hear the noise now?_____
If you need help suppressing the noise please ask the receptionist for a tinnitus report.

Have you experienced dizziness, imbalance or vertigo? Yes___No___
If yes, ask the receptionist for the balance history form.

Have you EVER been exposed to loud noise? Explosion___Factory___Farm___Firearms___Close by fireworks___ Lawn/garden___Motorcycle___Music___Power tools___Other_____

Who on either side of your family had a hearing problem? (Please write M for mother's side and P for father's side)

Great-grandmother_____great-grandfather_____grandmother_____grandfather_____

Aunt_____uncle_____mother_____father_____sister_____brother_____

When or how often have you had earwax removed from your ears?_____

Name of your regular physician_____

Yes___No___ Pain in or radiating to your ear

Yes___No___ Sudden or rapid loss of hearing in past 90 days

Yes___No___ Thyroid or goiter condition

Yes___No___ History of fungus infection

Yes___No___ Medication or diet to control diabetes or prediabetes_____

Yes___No___ Medication (including aspirin) for blood thinner_____

Yes___No___ High blood pressure, stroke (CVA) or TIA_____

Yes___No___ Allergic reaction to medication or skin contact irritants (i.e. nickel earrings) Please list_____

_____

Yes___No___ Ear surgery Please list when/procedure/ ear/surgeon_____

_____

MEDICAL HISTORY-

Please check if you have experienced or diagnosed with

| | | |
|---|---|---|
| ___Anemia/blood disease | ___Head trauma or unconscious | ___Migraines |
| ___Arthritis/Rheumatoid | ___Hepatitis A, B, or C | ___Multiple sclerosis |
| ___Asthma | ___High cholesterol | ___Mumps |
| ___Autoimmune disorder | ___HIV/aids | ___Neurological disorder |
| ___Bell's palsy | ___Iron deficiency | ___Parkinsons |
| ___Cancer treatments | ___Kidney or renal problems | ___Respiratory problems |
| ___Depression or anxiety | ___Liver disease | ___Scarlet fever |
| ___Eye disease/injury | ___Measles | ___Siezures |
| ___Genetic (hereditary disorder) | ___Meniere's disease | ___Tuberculosis |
| ___G.I. track problem | ___Meningitis | _____ |

Yes___No___ Worn or tried hearing instruments. If yes what did you like about them?_____

_____

What did you not like? difficulty hearing in noise___ my voice hollow or unnatural___ some sounds too loud___ too high pitched or tinny___ whistle or squeal___ cannot tell where sounds are coming from___ telephone___ TV___ Wind noise___ Other_____

Below-office use

ear canal- open___ cerumen_____dry____moist____1st turn bite_____smile_____

_____texture- soft_____med_____firm_____

behind auricle- narrow med large narrow med large

RIC length AD_____AS_____

_____

_____

Rev 2/14