Adult Audiology Case History

Name_____ Birth Date____/_____/_____
First Middle Last

Preferred Name_____ Appointment Date _____/_____/20_____

Accompanied by: _____
(Names and Relationships)

Your Face to Face Communication				
Spoken English	Sign Language			
Bilingual	Other Languages (List)			
Writing	Other (List)			
Current Employment				
Retired	Full Time	Part Time	Unemployed	Student
Occupations (Include Prior Primary and Secondary)				
How did your find out about us?				
Advertisement	Employer	Friends	Insurance	
Internet	Physician	Relatives	Other	
Names of Referral:				

Primary reason for today's visit_____
_____

CURRENT HEARING

Please think about the following situations in the past 30 days. (If your hearing fluctuated, use your best estimate of today's hearing.)	**Always Problem**	**Generally**	**About Half**	**Sometimes**	**No Problem**
I hear but do not understand					
Not understanding a whisper					
Determining where sounds come from					
Understanding when two are talking at the same time					
Multiple talkers and background noise					
Understanding TV if normal level for others					
Church auditorium or large Venue					
How often others say that you don't hear					
You feel your hearing worries or annoys you					

List 3 or more Situations, Locations, or People you would most like to hear better than you do now.

1._____
2._____
3._____

Please read each question and ***Circle***, ***Fill***, or ***Underline*** your answer.

Have your ever worn a Hearing Aid(s)? No Yes, Tried Only Yes, Past Experience

If "Yes" How would you rate your experience on a scale of 0 to 10

Terrible > 0 1 2 3 4 5 6 7 8 9 10 < Excellent

Assistive Listening Device Used: Alerting Audio Loop Captioned TV Remote Mic Wearable Amplifier

Phone Use (Select all that Apply) Left Ear Right Ear Either Amplified Captioned Speaker Mode

Factors Contributing

Normally which is your Better Ear? Left Ear Right Ear Similar

In the last 90 days have you had any of the following? No

Sudden or Rapid Loss of Hearing LE RE Both

Ear Pain or Discomfort LE RE Both

Ear Drainage, Bleeding, Open Sores LE RE Both

Fullness, Pressure in Ear LE RE Both

Hearing better some days than others LE RE Both

Do you have any tinnitus? (Noises in your Ears or Somewhere in Head) No Yes

If "Yes" where did it start? LE RE Both Head

Is the pitch: **High** (bird chirp, insects) **Low** (deep like a fog horn) **Other** _____

The Noise Occurs: Occasional Often Constant

Do you hear it now? No Yes

How often can you ignore it? Never Rarely Usually Almost Always

Have you noticed greater sensitivity to certain sounds or loud sounds within the last 7 years? No Yes

Dizziness, Loss of Balance, Vertigo in the past 10 years? No Yes

If "Yes" is it: Constant Comes and Goes Only Upon Movement Accompanied by Nausea

List Approximate Dates_____

Physician Diagnosed as:_____

Is there a family history of hearing loss? No Yes

If "Yes," Who? _____

If know, Why? _____

History of Loud Noise Exposure

Concert Gunfire Industrial Jet Ski Lawn/Tool

Motorcycle Played in Band Snowmobile Stereo Headphones Other_____

Noise Incidents:_____ Military Branch_____

Work (Company and How Long?)_____

Have you been exposed to loud noise within the last 14 hours? No Yes

If "Yes" did you wear Ear Protection? No Yes

Type of Protection: Foam Earplugs Wax Balls Earmuffs Silicon Plugs Universal Earplugs Custom Other

MEDICAL

Primary Physician: _____ Location: _____
(Full Name)

Do you "take" or have you "taken" Medication for the Following: No Yes

Arthritis	Cialis	Chemotherapy within	"__ mycin"	Diabetes
Blood Pressure	Daily Aspirin	the past year or	Long term IV	Type II
Blood Thinning	Viagra	planned.	Antibiotics	Type I

Do you have Allergies of any kind? (Seasonal or Constant, Skin Contact, Medication) No Yes

Please list all Allergies:_____

History of "Headaches" or "Migraines"? No Yes

If "Yes" does anything trigger them?_____

Have you sustained a Head injury? (Car Accident, Concussion, Fall, Other) No Yes

If "Yes" When and What happened? _____

Have you been diagnosed or feel that you may have Temporomandibular Joint Disorder (TMJ)? No Yes

Do you have Low Vision or Eye Disease? (Glaucoma, Cataracts, Macular Degeneration, Etc.) No Yes

If "Yes" please explain _____

Ear Wax Management: None; Ears Self-Clean Method at Home Others have Removed

If "Others" have removed wax, approximate number of times. _____

Fungal Ear Infection? No Yes

Hole in Eardrum? (Currently) in LE RE (Previously) in LE RE

Please list any ENT, Otologist consult/surgery _____

Are you: Left Handed Right Handed Mixed Handed

Do you have Arthritis, Stiffness, or Numbness in Fingers? No Yes

Do you have any implanted electronic devices? No Pacemaker Defibrillator Other_____

Do you have any of the following: (Select all that apply)

Asthma	Dementia	HIV/Aids	Meniere's Disease
Crohn's Disease	Facial Weakness	Hypothyroidism	Parkinson's Disease
Cytomegalovirus (CMV)	Hepatitis A, B, or C	Iron Deficiency	Radiation/Chemo
Depression or Anxiety	High Cholesterol	Kidney Disease	Seizures

Are you under the care of a Specialist? No Yes

If "Yes" First and Last Name and Specialty _____

Do you take any Medication or Supplements on a regular basis? No Yes

Please List Medication (Or provide a separate list to us)

Medication	Dosage (Strength)	Frequency	Form (Pill, Injection, Patch)	Reason for Medication

_____ _____
(Signature of Person Completing Form) (Date)