ADULT CASE HISTORY - AUDIOLOGY

PLEASE PRINT Today's Date: ____________

Last Name: ______________________________ First Name: ______________________ Middle Initial: _______

Birth Date: ______________________________ Gender: Male Female (please circle)

Street Address: ___________________________ City/State/Zip: ______________________________________

Home Phone: ___________________________ Work Phone: ______________________________________

Email: __________________________________ Place of Employment: ______________________________

How would you prefer to be contacted: (please check one)

____Home Phone ____Work Phone ____U.S. Mail ____E-mail

Family Physician: _________________________ Referred by: ______________________________________

Please check the appropriate answer. Fill in blanks where indicated.

SAMPLE

YES NO

___ ___ Do you feel you are hard of hearing? If so, which ear? Right Left Both

For how long? ____________________ Is the problem becoming worse? Yes No

___ ___ Do you have trouble understanding people when they talk?

___ ___ Have you recently experienced pain or drainage in your ears?

___ ___ Have you ever had bleeding from your ears? If so, which ear? Right Left Both

___ ___ Do you have noises in your ears? Which ear? Right Left Both
What does it sound like? ringing, clicking, buzzing, or other ______________________

___ ___ Do your ears feel plugged? If so, which ear? Right Left Both

___ ___ Do you have dizzy spells? If so, when was the last one? ____________________________
Please describe: ____

___ ___ Have you ever had an operation on your ears? If so, which ear? Right Left Both
What type of surgery? ____

___ ___ Have you ever had a doctor remove wax from your ears?
If so, how long ago? ____________________ Which ear? Right Left Both

___ ___ Is there a family history of hearing loss, such as in your parents, brothers or sisters?
If so, what type and whom? ____
____

___ ___ Have you ever worked around loud noises?

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YES	NO	
___	___	If so, did you wear ear protection?
		How long have you worked around loud noise? ________________________________

What type of loud noise? (please circle)

What type of loud noise?	factory work	construction	farm machinery
(please circle)	motorcycles	loud engines	power tools
	loud music	lawn mowers	military artillery

___ ___ Do you have any noisy hobbies?
___ ___ If so, do you wear ear protection?

What type of loud noise?	snowmobiles	motorcycles	dirt bikes
(please circle)	carpentry	power tools	loud engines
	loud music	gunfire	jet skis

___ ___ Have you ever worn a hearing aid? For which ear? Right Left Both
If so, when did you obtain it/them? ________________________________
What concerns do you have about your hearing aids? ________________________________
____

___ ___ Do you have any difficulties with your sense of touch or handling small objects?

___ ___ Do you have any serious vision problems? If so, what type? ________________________
____

Please indicate whether you have had any of the following health problems:
(Please check all that apply)

___ Allergies
___ Sinusitis
___ Meningitis
___ Scarlet Fever or Prolonged Low Fever
___ Prolonged High Fever
___ Mumps
___ Measles
___ Tuberculosis (TB)
___ Cytomegalovirus (CMV)
___ Syphilis
___ Hepatitis (A, B or C)
___ Diabetes
___ Heart Disease or High Blood Pressure
___ Hypothyroidism
___ Kidney Disease
___ Frequent Ear Infections
___ Other Disease of the Ear: ________________________________
___ Arthritis
___ Tremors (eg: Parkinson's Disease)
___ Multiple Sclerosis
___ Cerebral Palsy
___ Traumatic Brain Injury/Head Trauma
___ Stroke, Brain Attack, TIA or CVA
___ Alzheimer's Disease or Dementia
___ Concussion or Loss of Consciousness
___ Seizure Disorder
___ Other Neurological Disease: ____________________
___ Frequent Severe Headaches or Migraine
___ Developmental Disability
___ Temporomandibular Joint Disorder (TMJ)
___ Cleft Palate
___ Immune Deficiency Disorder
___ Cancer - What type? ________________________

What medications are you currently taking? ________________________________
____
____

Which of the following types of medications have you taken?

___ Diuretics
___ Antibiotics
___ Blood Pressure/Heart medication
___ Antimalarial medication
___ Anti-inflammatory or Arthritis medication
___ Chemotherapy
___ Cholesterol lowering medication
___ Immunosuppressant, eg: Transplant medication