Southern Vermont Audiology
5420 Main Street
Manchester Center, VT 05255
(802) 366-8020
Fax (802) 366-8030
svtaudiology.com

Adult Case History

Name: _____ Date of Birth: ____/_____/_____

Primary Care Physician _____

What is the reason for your visit today? _____

Have you noticed a change in your hearing? ☐ NO ☐ YES

Sudden / Gradual / Fluctuating (circle one) Right / Left / Both Ears (circle one)

Do you have a history of noise exposure? ☐ NO ☐ YES

☐ Recreational (e.g. guns/hunting, loud music, motorcycles, power tools)

☐ Occupational (e.g. factory, carpentry, construction)

☐ Military ☐ Other: _____

Do you experience tinnitus (e.g.ringing, buzzing, hissing)? ☐NO ☐YES When did it start? _____

Right / Left / Both Ears (circle one) Is it constant or intermittent? (circle one)

Describe the sound: _____ Is it distressing to you? ☐NO ☐YES

Do you have dizziness, vertigo, or loss of balance? ☐NO ☐YES – describe _____

Do you have history of head trauma? ☐NO ☐YES – describe_____

Do you have history of ear disease or ear surgery? ☐NO ☐Yes – describe_____

Do you have history of holes in your eardrums? ☐NO ☐YES – describe_____

Do you have a family history of hearing loss? ☐NO ☐YES – describe_____

Have you had your hearing tested before? ☐NO ☐YES – Where/When_____

Have you ever worn a hearing aid? ☐NO ☐YES – describe_____

(TURN OVER)

In the past 90 days have you experienced? Ear Pain / Ear drainage / Ear Infections (circle all that apply)

Have you ever had any of the following conditions? (circle all that apply)

Vision Loss	Skin Tags (on or near ear)	Heart Disease	Diabetes – type I or II
Dexterity Loss	Cleft Palate	Stroke	Kidney Disease
Arthritis	Memory Loss	Thyroid Disease	Lyme Disease
Covid-19	Cancer – describe _____		

Medications -**please list all including dosage & frequency/circle any that are new within the last 6 months**

_____

_____

_____

Does a hearing problem:

Cause you to feel embarrassed when meeting new people?	☐YES	☐SOMETIMES	☐NO
Cause you to feel frustrated when talking to members of your family?	☐YES	☐SOMETIMES	☐NO
Cause you difficulty when visiting friends, relatives, or neighbors?	☐YES	☐SOMETIMES	☐NO
Cause you to attend events less often than you would like?	☐YES	☐SOMETIMES	☐NO
Cause you to have arguments with family members?	☐YES	☐SOMETIMES	☐NO
Cause you difficulty when listening to TV or radio?	☐YES	☐SOMETIMES	☐NO
Cause you difficulty when in a restaurant with family or friends?	☐YES	☐SOMETIMES	☐NO
Limit or hamper your personal/social life?	☐YES	☐SOMETIMES	☐NO
Do you have difficulty hearing when someone speaks in a whisper?	☐YES	☐SOMETIMES	☐NO
Do you feel handicapped by a hearing problem?	☐YES	☐SOMETIMES	☐NO

Please describe your primary area of hearing difficulty: _____

On a scale of 1 to 10 **(1 being the worst and 10 being the best):**

How would you rate your overall hearing ability? _____

On a scale of 1 to 10 **(1 being not motivated and 10 being very motivated):**

How motivated are you to do something about your hearing loss? _____

SIGNATURE: _____ DATE: _____/_____/_____

Rev.2/18/22