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Adult Case History

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

What is the reason for your visit today? _____

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

If yes: Sudden Gradual Fluctuating (circle one)

Right Left Both Ears (circle one)

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

Do you experience tinnitus? (e.g.ringing, buzzing, noise) ☐NO ☐YES – describe_____

How Long? _____ Right Left Both Ears (circle one)

Is it constant or intermittent? (Circle one)

Is it distressing to you? ☐NO ☐YES – describe _____

Do you have a history of noise exposure? ☐NO ☐YES – (circle all that apply)

Heavy Equipment Guns Loud Music Power Tools
Motorcycles other: _____

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

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

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

Have you ever had ear surgery? ☐NO ☐YES – describe_____

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

(TURN OVER)

In the past 90 days have you experienced? (Circle all that apply)

Ear Pain Ear discharge or drainage Ear Infections

Physician who treated you: _____

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

Vision Loss	Skin Tags (on or near ear)	Memory Loss	Stroke
Cleft Palate	Heart Disease	Diabetes	Dexterity problems
Arthritis	Cancer – describe_____		

Have you used any tobacco products in the past 24 months?

(cigarette,pipe,cigar,E-cigarette,chew/snuff) ☐NO ☐YES – describe_____

Medication List **(please list all including dosage & frequency and circle any that are new within the last 6 months)** _____

_____

_____

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

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

If you do **not** wear hearing aids please answer the following:

Do you avoid social situations because you have difficulty hearing?	☐YES	☐NO
Do you find that you have to ask people to repeat themselves?	☐YES	☐NO
Do you sometimes hear words but do not understand them?	☐YES	☐NO
Do you have difficulty understanding people in noisy places?	☐YES	☐NO
Have you been told that you speak loudly?	☐YES	☐NO
Do others complain that you have the TV turned up too loud?	☐YES	☐NO
Do you find loud sounds bothersome?	☐YES	☐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? _____

SIGNATURE: _____ DATE: _____/_____/_____