

**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.**

**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?

YES NO

\_\_\_ \_\_\_ If so, did you wear ear protection?  
\_\_\_ \_\_\_ How long have you worked around loud noise? \_\_\_\_\_  
What type of loud noise? (please circle) factory work construction farm machinery  
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? (please circle) snowmobiles motorcycles dirt bikes  
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                            | ___ Arthritis                              |
| ___ Sinusitis                            | ___ Tremors (eg: Parkinson's Disease)      |
| ___ Meningitis                           | ___ Multiple Sclerosis                     |
| ___ Scarlet Fever or Prolonged Low Fever | ___ Cerebral Palsy                         |
| ___ Prolonged High Fever                 | ___ Traumatic Brain Injury/Head Trauma     |
| ___ Mumps                                | ___ Stroke, Brain Attack, TIA or CVA       |
| ___ Measles                              | ___ Alzheimer's Disease or Dementia        |
| ___ Tuberculosis (TB)                    | ___ Concussion or Loss of Consciousness    |
| ___ Cytomegalovirus (CMV)                | ___ Seizure Disorder                       |
| ___ Syphilis                             | ___ Other Neurological Disease: _____      |
| ___ Hepatitis (A, B or C)                | ___ Frequent Severe Headaches or Migraine  |
| ___ Diabetes                             | ___ Developmental Disability               |
| ___ Heart Disease or High Blood Pressure | ___ Temporomandibular Joint Disorder (TMJ) |
| ___ Hypothyroidism                       | ___ Cleft Palate                           |
| ___ Kidney Disease                       | ___ Immune Deficiency Disorder             |
| ___ Frequent Ear Infections              | ___ Cancer - What type? _____              |
| ___ Other Disease of the Ear: _____      |  |

What medications are you currently taking? \_\_\_\_\_

Which of the following types of medications have you taken?

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