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?	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