LeMay HEARING & BALANCE

Adult Case History

Name _____ Date _____

General Medical History

Why did you schedule an appointment? _____

_____

List any medications you are currently taking or bring in medication card with the information _____

_____

Do you or have you experienced any of the following?

☐ Ear pain	☐ Ear drainage	☐ Head/ear trauma
☐ Dizziness/lightheadedness	☐ Medical treatment for ears	☐ Ringing noises in ears
☐ Ear surgery	☐ Sinusitis	☐ Chemotherapy
☐ Allergies	☐ Fullness in head or ears	☐ Treatment with intravenous antibiotics

Comments regarding any of the above or other pertinent medical history _____

_____

Hearing Health

How long have you been aware of a difficulty hearing? _____

Is there any family history of hearing loss? _____

Have you been exposed to loud sounds at work? With hobbies? ☐ Yes ☐ No

_____

Have you ever worn hearing aids before? ☐ Yes ☐ No

What type/model and for how long? _____

Why did you stop wearing them? _____

Factors affecting your communication include the listening situation and/or background environment you are in. Please check the situations you have difficulty with and would like to improve:

☐ Restaurants

☐ Television

☐ In the car

☐ One-on-one conversation in quiet

☐ Understanding someone talk from another room

☐ Hearing the front doorbell/knock

☐ Meetings (when there is a talker speaking from a distance)

☐ Large groups

☐ Radio/music

☐ Phone

☐ Hearing the phone ring from another room

☐ One-on-one conversation in noise

☐ Church (echoic environments)

☐ Hearing female/child speech

☐ Other _____

☐ Other _____

How motivated are you to try amplification? (circle one)

1 (Not at all) 2 (A little) 3 (Somewhat) 4 (Considerably) 5 (Very)

List 3 goals for improvement of communication or symptoms (For example: 1. Understand what my spouse is saying 2. Understand speech on the phone 3. Be able to follow conversations while in restaurant)

1. _____

2. _____

3. _____

Sometimes ringing in the ears (tinnitus) can also accompany hearing loss.

Do you experience tinnitus? ☐ Yes ☐ No

If yes, what does it sound like? (check all that apply)

☐ Ringing ☐ Roaring ☐ Chirping ☐ Whooshing ☐ Buzzing ☐ High pitched ☐ Low pitched

Is your tinnitus constant or fluctuating? (circle one)

Does tinnitus affect your quality of life? ☐ Yes ☐ No

Please explain _____

Is your tinnitus brought on by anything? (medications, loud noises, etc.) ☐ Yes ☐ No

Please explain _____

Do you have any of the following?

Manual dexterity problems/decreased feeling in your fingers? ☐ Yes ☐ No

An active ear infection or drainage from your ear(s)? ☐ Yes ☐ No