



Adult Case History

Name _____ Date _____

General Medical History

Why did you schedule an appointment? _____

Is this a legal case? Yes No _____ Auto comp Workers' comp _____

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
- Smoker (Current Previous)

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

Hearing Health

How long have you noticed hearing difficulties? _____

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Restaurants | <input type="checkbox"/> Meetings (when there is a talker speaking from a distance) | <input type="checkbox"/> One-on-one conversation in noise |
| <input type="checkbox"/> Television | <input type="checkbox"/> Large groups | <input type="checkbox"/> Church (echoic environments) |
| <input type="checkbox"/> In the car | <input type="checkbox"/> Radio/music | <input type="checkbox"/> Hearing female voices/child speech |
| <input type="checkbox"/> One-on-one conversation in quiet | <input type="checkbox"/> Phone | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Understanding someone talking from another room | <input type="checkbox"/> Hearing the phone ring from another room | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hearing the front doorbell/knock | | |

How motivated are you to try hearing aids or other types of amplification? (circle one)

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

List three 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 a restaurant)

1. _____
2. _____
3. _____

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

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 _____