ADULT AUDIOLOGICAL CASE HISTORY

Date _____

Name _____ Date of Birth _____

Referral Source _____

1. How would you best describe your hearing? More than one may apply.
   - ○ Hearing is fine with no concerns
   - ○ Able to hear but not clearly
   - ○ Difficulty hearing in noisy environments
   - ○ Difficulty hearing from a distance
   - ○ Difficulty hearing in group situations
   - ○ Unable to hear

2. Do you feel that your hearing is better in one ear versus the other? Yes No
   If yes, which ear is better? ○Right ○Left

3. Have you previously had a diagnostic hearing test? Yes No
   If yes, how long ago? _____ Results? _____

4. Have hearing aids ever been recommended? Yes No
   If yes, are you currently wearing hearing aids? Yes No
   If yes, ○Right ear ○Left ear ○Both ears

5. Do you ever experience noises in either ear (ringing, hissing, buzzing)? Yes No
   If yes, describe: _____
   When did the sound begin? _____
   How frequently? ○Rarely ○Occasionally ○Daily ○Constantly, sound does not stop
   Which ear? ○ Right Ear ○ Left Ear ○ Both Ears ○ Not sure

6. Do you have a history of ear infections? Yes No
   If yes, when was the last infection?_____

7. Have you ever had ear surgery? Yes No
   Is yes, what surgery?_____

8. Is there a family history of hearing loss? Yes No
   If yes, who? _____
   If known, why?_____

9. Have you ever been exposed to loud noise, recently or in the past? Yes No
   If yes, please explain_____

Please check (√) if you have experienced any of the following:

○ Excessive ear wax ○ Ear drainage/bleeding ○ Swimmer's Ear
○ Ear pressure/fullness ○ Popping sensation in the ear ○ Ear pain
○ Fluctuating hearing loss ○ Fluid behind the eardrum ○ Dizziness/Vertigo
○ Sensitivity to loud noises

Please check (√) if you have been diagnosed with any of the following:

○ Otosclerosis ○ Cholesteatoma ○ Sudden hearing loss
○ Labyrinthitis ○ Meniere's disease ○ Barotrauma
○ Permanent hearing loss ○ Acoustic neuroma ○ Bell's palsy
○ Ossicular dislocation/fixation

Medical History:

1. Have you ever used tobacco products of any kind? Yes No

2. How many alcoholic drinks/week do you consume? _____

3. Please check (√) if you have experienced any of the following:

○ Heart disease ○ Mumps ○ Kidney or renal problems
○ Stroke/TIA ○ Meningitis ○ Chronic sinus infections
○ Diabetes ○ Measles ○ Environmental allergies
○ High blood pressure ○ Scarlet fever ○ Cancer
○ Hypothyroidism ○ HIV/AIDS ○ Radiation/chemotherapy
○ Asthma ○ Tuberculosis ○ Long term IV antibiotics
○ Mental illness ○ Visual Problems ○ Head trauma
○ Depression or anxiety ○ Hepatitis A, B or C ○ Loss of Consciousness
○ Migraines ○ Liver Problems ○ Exposure to chemicals/solvents

4. Please list your current prescriptions:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature of person completing history Date

_____

Relationship to patient