



ADULT CASE HISTORY FORM

The following information is confidential. Today's Date: _____

Name: _____ DOB: _____

GENERAL

Do you think you have a hearing problem YES NO

If yes, how long have you noticed this problem?

What do you feel is the cause of your hearing loss?

Was the onset gradual or sudden?

In which ear do you hear the best? Same in both ears Right Left

Have you ever been exposed to loud noises? YES NO

If yes, please describe:

Does anyone in your family have hearing loss? YES NO

If so, who?

Have you ever had your hearing tested? YES NO

If yes, when and what were the results?

MEDICAL

Have you ever had earaches or drainage from your ears? YES NO

Have you ever had medical/surgical treatment for your ears? YES NO

Do you notice any buzzing, ringing or roaring in your ears? YES NO

If yes, which ear? Right Left

San Marcos Hearing Center
300 S. CM Allen Pkwy Ste. 300A
San Marcos, TX 78666
Phone: (512) 667-6904

Seguin Hearing Center
628 N. HWY. 123 Bypass, Ste. 2
Seguin, TX 78155
Phone: (830) 399-4195

Floresville Hearing Center
1303 Hospital Blvd.
Floresville, TX 78114
Phone: (830) 399-4195



Have you ever had any of the following:

- meningitis scarlet fever seizures vision problems arthritis
- measles injury to head allergies depression/anxiety hypertension
- mumps diabetes high fever pacemaker communicable disease

Please list any medications (including non-prescriptions) you are currently taking or have taken recently: _____

HEARING HISTORY

Do you have difficulty with any of the following:

- Watching TV Using the telephone Meetings Restaurants Worship service

Do you have problems hearing any of the following:

- Telephone ring Doorbell or knocking Fire/smoke detector Sirens
- Alarm clock Baby cry

Which ear do you use on the telephone? Right Left

HEARING AID HISTORY

Have you ever worn a hearing aid? YES NO

Do you use a hearing aid now? YES NO

If YES, how long have you had a hearing aid? _____

On which ear do you use the hearing aid? Right Left Both ears

Do you wear it regularly? YES NO

Do you feel you benefit from it? YES NO

Please rank the following in order of importance (1-4), if a hearing aid is recommended for you: _____ Improved hearing in quiet _____ Improved hearing in noise
_____ Cosmetic appearance _____ Expense

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