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ADULT CASE HISTORY

NAME:_____ DATE:_____

Please give a brief explanation of your hearing problem:_____
_____
_____

1. Have you ever had a hearing test? YES NO
   If yes, When? _____ Where?_____

   Results:_____

2. Do you have a better ear? YES NO

3. Does your hearing fluctuate? YES NO

4. Does anyone in your family have a hearing loss that was not acquired through aging? YES NO
   If yes, who? _____ What age?_____

5. Do you suffer from head noise (ie: ringing or buzzing)? YES NO
   If yes, can you tell where? RIGHT MID LEFT

6. Have you ever experienced dizzy spells? YES NO

7. Have you ever been exposed to noise - recreational or work related? YES NO

8. Do you have a history of any of the following medical problems? (Please circle)

Ear Infections	Upper Respiratory Infections
Kidney	Diabetes
Head Injury	High Blood Pressure

9. Are you currently taking medication?
   If yes, please indicate:_____

10. Have you ever worn a hearing aid? YES NO RIGHT LEFT

11. How often do you wear it?_____

12. Are you a smoker? If so, for how long and how often? YES NO
    _____
    _____