AUDIOLOGY AND HEARING AID SERVICES

ADULT CASE HISTORY

Name: _____ Date of Birth: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Spouse: _____ How did you learn about us? _____

Physician: _____ Clinic address, if known: _____

E-mail Address: _____

* * All contact information, including e-mail address, will be used strictly for issues related to today's visit and any necessary future contact. It will not be disclosed to outside sources beyond the scope of our patient privacy policy. Your initials: _____

- Ear, Hearing & Noise Exposure History -

(Please circle appropriate answer and provide more information where necessary.)

Known Hearing Loss? Yes No
Right Left Both
How long? _____
Gradual? Sudden? Fluctuating?

Past Ear Surgery? Yes No
Right Left Both
Describe: _____

Recent Ear Pain? Yes No
Right Left Both
Describe: _____

Recent Ear Drainage? Yes No
Right Left Both
Describe: _____

Full/plugged sensation? Yes No
Right Left Both
How long? _____

Tinnitus (ringing/other noises in ears)? Yes No
If yes, please answer tinnitus assessment form

Dizziness/Balance problems? Yes No
Does the room spin? Yes No
How long have you had problem? _____
How frequently does it occur? _____
Duration of an episode? _____

Family History of Hearing Loss? Yes No
Who? _____

Have you ever worked in noise? Yes No
Military? Yes No
Describe: _____

Noisy Hobbies:
Firearm use? Yes No
Loud music/concerts? Yes No
Other: _____

- Other Medical History -

(Please circle if you have or have had any of the following)

Allergies
Cancer
Cerebral Palsy
Diabetes
Head Injury
Heart Attack
High Blood Pressure
HIV/AIDS
Kidney Disease
Meningitis
Multiple Sclerosis
Mumps
Stroke
Other communicable disease

Other Significant Health Issues: _____
_____
_____
_____
_____
_____

Medications: _____
_____
_____
_____
_____
_____

*** * PLEASE TURN OVER * ***

H E A R I N G L O S S A S S E S S M E N T

	Yes	Sometimes	No
1. Does your hearing problem cause you to feel embarrassed?	☐	☐	☐
2. Does your hearing problem cause you to feel frustrated when talking to family?	☐	☐	☐
3. Do you have difficulty hearing when someone speaks in a whisper?	☐	☐	☐
4. Do you believe your hearing problem has affected work or similar situations?	☐	☐	☐
5. Does your hearing problem cause you difficulty when visiting friends or family?	☐	☐	☐
6. Does your hearing problem cause you to avoid large group situations?	☐	☐	☐
7. Does your hearing problem cause you to have arguments with friends or family?	☐	☐	☐
8. Does your hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
9. Does your hearing problem hamper your personal or social life?	☐	☐	☐
10. Does your hearing problem cause you difficulty when in a noisy situation like a restaurant or party?	☐	☐	☐

How important is it for you to improve your hearing? (Please Circle)

Not Important 1 2 3 4 5 Very Important

How motivated are you to wear and use hearing aids? (Please Circle)

Not Motivated 1 2 3 4 5 Very Motivated

Do you think hearing aids will improve your hearing? (Please Circle)

Not at all 1 2 3 4 5 They Will Help

If you have worn hearing aids before, please answer the following:

H E A R I N G A I D H I S T O R Y

How long have you worn hearing aids? _____

Where did you purchase them? _____

How satisfied are you with your hearing aid(s) in the following situations?

At home, one-on-one conversations	□ Good	□ OK	□ Poor
In background noise (i.e. restaurants)	□ Good	□ OK	□ Poor
On the Telephone	□ Good	□ OK	□ Poor
On a cellular telephone	□ Good	□ OK	□ Poor
Riding in the car	□ Good	□ OK	□ Poor
At Work	□ Good	□ OK	□ Poor
Television	□ Good	□ OK	□ Poor
In a large room	□ Good	□ OK	□ Poor

Are you here to replace your hearing aids if something better is available? Yes Maybe No

*** * P L E A S E T U R N O V E R * ***