Patient Name: Patient DOB:
Appointment date: Seen by:

CASE HISTORY: Instructions: **Check or circle all that apply**. **Elaborate as needed**. VA REQUIRES ALL QUESTIONS BE ANSWERED FOR EVALUATION TO BE SUBMITED.

Did you bring medical records?

- Yes. If yes, describe records: _____
- No

Do you currently have a stable living situation?

- Yes
- No, I am homeless

History:

a. Please describe your chief compliant:

_____
_____
_____

b. **When was the onset of your chief complaint?** _____

c. What difficulties, if any, do you have with your hearing?

_____
_____
_____
_____

d. **Please describe your military service history (branch, years of service, combat zone, deployments, medals, etc.):**

_____
_____
_____

e. History of Noise exposure:

- **Military Noise Exposure, please describe:**

  _____
  _____
  _____

- **Occupation Noise Exposure:**
  i. Pre-Service:_____
  ii. Post Service:_____
- **Recreational Noise/Social Noise Exposure:**
  i. Pre-Service:_____
  ii. During Service:_____
  iii. Post-Service:_____

f. Please describe relevant **family history of hearing loss:**

_____
_____

g. Have you been diagnosed with and/or received any of the following?

- Otosclerosis
- Labyrinthitis
- Permanent hearing loss
- Sudden hearing loss
- Bell's palsy
- Cholesteatoma
- Meniere's disease
- Ossicular dislocat/fixation
- Barotrauma
- Acoustic neuroma
- Meningitis / Measles
- Cancer
- Radiation/chemotherapy
- Long term IV antibiotics
- Head Trauma

Patient Name: Patient DOB:
Appointment date: Seen by:

Functional Impact of **HEARING LOSS**: (note: RINGING IN THE EARS IS DISCUSSED IN THE NEXT SECTION)

Does your **hearing loss** impact ordinary conditions of daily life, including the ability to work?
Yes / No
If yes, in your own words, describe the effect of disability (i.e. the current complaint of hearing loss on occupational functioning and daily activities) _____
_____
_____
_____

Daily life impacts of hearing loss: _____
_____
_____
Work activities affected from hearing loss: _____
_____
_____

TINNITUS:
Does the veteran report recurrent tinnitus (ringing or sounds in the ears)? YES / NO
Date of Onset (if unsure, approximate): _____
Describe the **circumstances of the initial onset of tinnitus**: _____
_____
_____

Is the current tinnitus (circle):
- Intermittent OR Constant

Describe course between onset and last episode of tinnitus (e.g. how frequently in a year do you have tinnitus?) _____

Functional impact of **tinnitus**:
Does your **tinnitus** impact ordinary conditions of daily life, including the ability to work?
Yes / No
If yes, in your own words, describe the effect and impact of disability (i.e. the current complaint of hearing loss on occupational functioning and conditions of daily life): _____
_____
_____
Daily life impacts of tinnitus:
_____
_____
Work activities affected from tinnitus:
_____
_____