



## 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 \*\***

# HEARING LOSS ASSESSMENT

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

### 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:*

## HEARING AID HISTORY

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	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
In background noise (i.e. restaurants)	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
On the Telephone	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
On a cellular telephone	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
Riding in the car	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
At Work	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
Television	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
In a large room	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor

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

**\*\* PLEASE TURN OVER \*\***