Adult Case History Form

Patient Name: _____ **Date of Completion:** _____

Date of Birth: _____ **Gender:** _____

Current Employment Status: [ ] Full time [ ] Part-time [ ] Retired [ ] Unemployed

Current Employer: _____ **Position:** _____

Do you currently use recreational drugs? [ ] Yes [ ] No

Do you currently use any tobacco products? [ ] Yes [ ] No

Do you currently drink alcoholic beverages? [ ] Yes [ ] No

Medical History

Current Medications:

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Or if you have a medication list, please bring it with you to your appointment

Allergies (foods, medications, plastics, etc.):

_____

Have you experienced any of the following major medical conditions (please check all that apply):

[ ] AIDS/HIV	[ ] Genetic Disorders	[ ] Meningitis
[ ] Arthritis	[ ] Headaches	[ ] Mumps
[ ] Blood Disorders	[ ] Head Injury	[ ] Scarlet Fever
[ ] Cancer	[ ] Heart Problems	[ ] Stroke
[ ] Chicken Pox	[ ] High Blood Pressure	[ ] TMJ
[ ] Depression	[ ] High Fevers	[ ] Typhoid
[ ] Diabetes	[ ] Influenza	[ ] Vascular Problems
[ ] Diphtheria	[ ] Malaise	[ ] Other:
[ ] Encephalitis	[ ] Malaria	
[ ] Fatigue	[ ] Measles	

Please check all medical symptoms or conditions that apply:

Eye problems (such as blurred or double vision, pain):	[ ] Yes	[ ] No
Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues):	[ ] Yes	[ ] No
Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations):	[ ] Yes	[ ] No
Respiratory issues (such as shortness of breath, cough, wheezing):	[ ] Yes	[ ] No
Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain):	[ ] Yes	[ ] No
Musculoskeletal issues (such as joint pain, swelling, recent trauma):	[ ] Yes	[ ] No
Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness):	[ ] Yes	[ ] No
Psychiatric issues (such as depression, anxiety, compulsions):	[ ] Yes	[ ] No
Endocrine symptoms (such as frequent urination, hot flashes):	[ ] Yes	[ ] No
Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands):	[ ] Yes	[ ] No
Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency):	[ ] Yes	[ ] No

Comments related to Review of Symptoms above:

Audiologic History

Do you experience hearing loss? [ ] Yes [ ] No

If so, which ear? [ ] Right [ ] Left [ ] Both

If you experience hearing loss, which best describes it? [ ] Gradual [ ] Fluctuating [ ] Sudden

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Have you ever had a hearing test? [ ] Yes [ ] No

If so, when: _____

Have you ever seen an Ear, Nose & Throat Physician? [ ] Yes [ ] No

If so, please list Physician's name and date seen: _____

Which type of phone do you use? [ ] Landline [ ] Mobile [ ] Both

If mobile: [ ] iPhone [ ] Android

Which ear do you typically use to talk on the telephone: [ ] Right [ ] Left

Have you ever worn or tried a hearing aid or amplifier? [ ] Right ear [ ] Left ear [ ] Both ears

What type and/or style of hearing aid or amplifier: _____

Please describe your experience: _____

Please check all of the medical conditions that apply:

[ ] **Developmental disorder/delay**

If checked, please explain: _____

[ ] **Dizziness or unsteadiness**

If checked, is it accompanied by: [ ] Vomiting [ ] Nausea [ ] Ear Noises

[ ] **Ear deformity**

If checked: [ ] Right ear [ ] Left ear [ ] Both ears

[ ] **Ear drainage**

If checked: [ ] Right ear [ ] Left ear [ ] Both ears

[ ] **Ear pain**

If checked: [ ] Right ear [ ] Left ear [ ] Both ears

[ ] **Family history of hearing loss**

If checked, who is the family member: _____

[ ] **History of ear infections**

If checked: [ ] Right ear [ ] Left ear [ ] Both ears

[ ] **History of earwax buildup**

If checked, how often do you have it removed: _____

[ ] **History of noise exposure**

If checked, please describe:

[ ] **Previous ear surgery**

If checked: [ ] Right ear [ ] Left ear [ ] Both ears

If so, when: _____

[ ] **Tinnitus/ringing/noises in ears**

If checked: [ ] Right ear [ ] Left ear [ ] Both ears

If so, frequency: _____

[ ] **Other (please describe):** _____

Hearing Handicap Screening (please select the most appropriate response):

Does a hearing problem cause you to feel embarrassed when meeting new people?

[ ] Yes [ ] No [ ] Sometimes

Does a hearing problem cause you to feel frustrated when talking to members of your family?

[ ] Yes [ ] No [ ] Sometimes

Do you have difficulty hearing when someone speaks in a whisper?

[ ] Yes [ ] No [ ] Sometimes

Do you feel handicapped by a hearing problem?

[ ] Yes [ ] No [ ] Sometimes

Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?

[ ] Yes [ ] No [ ] Sometimes

Does a hearing problem cause you to attend lectures or religious services less often than you would like?

[ ] Yes [ ] No [ ] Sometimes

Does a hearing problem cause you to have arguments with family members?

[ ] Yes [ ] No [ ] Sometimes

Does a hearing problem cause you difficulty when listening to TV or radio?

[ ] Yes [ ] No [ ] Sometimes

Do you feel that any difficulty with your hearing limits or hampers your personal or social life?

[ ] Yes [ ] No [ ] Sometimes

Does a hearing problem cause you difficulty when in a restaurant with relatives and friends?

[ ] Yes [ ] No [ ] Sometimes