Adult Case History Form

Patient Name_____ Birth date _____ Age _____

What is your primary concern for today's visit? _____

How would you rate your hearing? Circle one. Excellent Good Fair Poor

When did you first notice hearing difficulty? _____

Do you know what caused your hearing loss? _____

Did your hearing loss occur suddenly? No Yes

Does your hearing fluctuate? No Yes

Is one ear better than the other? No Yes: Right Left

Do you hear buzzing, ringing, or other noises in your ears? No Yes

If YES, is the noise constant? No Yes

Which ear do you hear it in? Right Left Both

How bothersome is it? None Slight Moderate Severe

Do you feel any pressure or fullness in your ears? No Yes: Right Left Both

Do you experience any ear pain? No Yes: Right Left Both

Do you have drainage from your ears? No Yes

Do you experience dizziness or vertigo? No Yes

If YES, is it constant? No Yes

When did it begin? _____

Have you used tobacco products in the past 24 months? No Yes

Please circle any that apply:

High Blood Pressure	Heart Disease	Diabetes	Ear wax problems
History of ear infections	Ear surgery	Noise exposure	Family history of hearing loss
Allergies/sinusitis	Cancer	Memory Loss concerns	

Other chronic medical conditions _____

Do you use hearing protection around hazardous noise? No Yes

Do you currently wear hearing aids? No Yes

How Long? _____ Which ear? Right Left Both

Please list any medications taken on a regular basis **on back of form**. →

_____ _____

Signature patient/parent or guardian (please circle) Date

Patient Medication Information

Name:_____ DOB: _____ DATE:_____

Please list all medications below.
(Including Over the Counter/Vitamins/Herbal Supplements)

Medication	Dosage/Strength	Frequency	Route of administration (oral, injection, etc.)

Reviewed by: Clinician Date

_____ _____

_____ _____

_____ _____