



Adult Case History Form

DATE: _____

FILE NO: _____

Name: _____ (Mr. Mrs. Ms. Dr.)

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers:

Home: _____ Work: _____ Cell: _____

Birth Date: _____ Occupation: _____

Referral Source: _____

Student Clinician(s): _____

Adult Case History Form

FILE NUMBER _____ Patient Initials _____ Age _____ Date _____

Chief Complaint: Hearing Loss (right, left, both) Tinnitus/Ringing Dizziness
Listening in background noise No hearing problems noticed

If you have a hearing problem, how long have you noticed this difficulty _____

Has your hearing ability changed recently? no yes (sudden or gradual)

Have you ever been exposed to loud sounds, either recently or in the past? yes no

If yes please mark all that apply: Farm machinery Power Tools Military
Hunting/shooting Factory Noise (with or without ear protection) Airplanes
Music Car stereo I-Pod Concerts Recreational vehicles (ATV etc.)

Have you seen an Ear, Nose and Throat Physician yes no

If yes, why did you see the physician? _____

Have you had ear surgery before? yes no

If yes, when did you have the surgery and for what problem? _____

Do you know of other family members who have hearing loss? yes no If yes, who _____

List all medications that you have taken within the last 3 months or take now on a regular basis. Explain what the medication is for and how long you have taken it. Include non-prescription (holistic, natural etc.) medications as well.

Medication: _____ How long _____ For _____

Medication: _____ How long _____ For _____

Medication: _____ How long _____ For _____

Please mark any of the following conditions that you currently have or have had in the past.

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Head injury	<input type="checkbox"/> Neurological	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Bell's palsy	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> symptoms	<input type="checkbox"/> Tinnitus/Ringing in the ear
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Vision Trouble
<input type="checkbox"/> Dizziness	<input type="checkbox"/> HIV		

Have you ever worn a hearing aid yes no If yes, when _____