**ADULT CASE HISTORY**

Patient Name: Age: Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Concern:**

* HEARING LOSS \_\_\_\_RIGHT EAR \_\_\_\_LEFT EAR
* DIFFICULTY HEARING \_\_\_\_IN QUIET \_\_\_\_IN NOISE
* DIFFICULTY UNDERSTANDING \_\_\_\_TELEPHONE \_\_\_\_TELEVISION
* TINNITUS/RINGING IN EARS
* DIZZINESS
* SUDDEN OR RAPID HEARING LOSS

**How long have you noticed this difficulty?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who referred you to us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL**

**Please check any of the following that you currently have or have had in the past:**

 □ EAR INFECTIONS □ FLUID BEHIND EARDRUM □ EAR PAIN OR DRAINAGE

 □ HOLE OR PERFORATED EARDRUM □ TUBES IN EARS □ EXCESSIVE EAR WAX

 □ FAMILY HISTORY OF HEARING LOSS □ HISTORY OF EAR SURGERY

**Have you ever been seen by an Ear, Nose and Throat Specialist?** YES NO Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When/Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke?** YES NO FORMER When did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink alcohol?** YES NO #of drinks per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you use drugs for reasons that are not medical?** YES NO

If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take any medications on a regular basis? Please list below or we can copy a list if you have it with you:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OVER**

**ADULT CASE HISTORY cont.**
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**HEARING**

**Have you had your hearing tested before?** YES NO When/Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had excessive noise exposure?** YES NO

 If yes, please specify:

 □ Military □ Hunting/Shooting

 □ Power Tools □ Factory Noise

 □ Music □ Farm Machinery

 □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you feel your hearing loss is caused from work related exposure?** YES NO

**If you are currently using a hearing aid, or have in the past, please answer the following:**

1. Which ear was aided? LEFT RIGHT BOTH
2. How long have you used a hearing aid? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What would you improve with your current hearing aid/s? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you interested in discussing hearing aids today?** YES NO

Please tell us anything else you want to share about your hearing:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed and Updated:

\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

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