



ADULT CASE HISTORY

Patient Name: _____ Date of Birth: _____ Age: _____

Referred By: _____

Primary Reason for Today's Visit: _____

HEARING

Do you have any problems with hearing? yes / no

Please describe: _____

For how long? ____ years ____ months

Did the hearing loss begin gradually or was it sudden? _____

Have you ever had your hearing tested? yes / no

If yes, when was your last test and what were the results? _____

Do you have a history of ear infections? yes / no

If yes, how many in one year? _____

Have you ever been evaluated by an ENT/otolaryngologist (ear doctor)? yes / no

If yes, please explain: _____

Do you have ear pain? yes / no

Do you have ear drainage? yes / no

Have you had any ear surgeries? yes / no (if yes, right / left / both)

Describe: _____

TINNITUS (ringing/buzzing/noises in the ear)

Do you have any tinnitus? yes / no If yes, for how long? ____ years ____ months

Did the tinnitus begin gradually or was it sudden? _____

Please rate your tinnitus (circle one):

Not bad - somewhat noticeable - somewhat interferes - very noticeable - very bothersome - extremely annoying

DIZZINESS/BALANCE

Do you have any dizziness/balance problems? yes / no For how long? ____ years ____ months

Please describe: _____

Have you previously been treated for dizziness? yes / no

OTHER RELEVANT HEALTH ISSUES

How would you describe your overall health? _____

Do you have any allergies? yes / no

Have you ever been exposed to loud noise? yes / no

Other relevant health history: _____

HEARING AID HISTORY

Have you ever tried a hearing aid? yes / no

Do you currently wear a hearing aid(s)? yes / no If yes, make/model/age: _____

Please describe your most difficult listening situation: _____