ADULT CASE HISTORY

Name:_____ Age: _____ Birth date: _____

Referred by: _____

- Primary complaint: _____
- Do you have hearing problems? Yes _____ No_____
- Which ear? Right _____ Left _____ Both _____
- Has the hearing loss been: Gradual? _____ Sudden? _____ Fluctuating? _____
- Do you presently use a hearing device? Yes _____ No _____ For how long? _____
- Are you interested in using a hearing device? Yes _____ No _____ Not sure _____
- Do you have problems on the telephone? Yes____ No____
- Do you hear noises in your ears or head? Yes_____ No _____
  Which ear? Right _____ Left _____ Both _____
  How often do you hear noises? Constantly _____ Occasionally _____ Rarely _____
- Do you ever have a feeling of fullness, stuffiness or pain in your ears? Yes _____ No _____
- Do you ever experience facial numbness, weakness or tingling? Yes _____ No _____
- Circle if you are ever 1. Dizzy 2. unsteady or off-balance?
  Is your dizziness accompanied by nausea? Yes _____ No _____
  Vomiting? Yes _____ No _____
  Noises in your ears? Yes _____ No _____
- Have you ever had ear surgery? Yes _____ No _____
  Describe: _____
- Have you ever been exposed to loud noises? Yes _____ No _____
  Describe: _____
  How recently? _____
- Does anyone in your family have a hearing problem? Yes _____ No _____
- Are you currently taking any medication? Yes _____ No_____ Describe: _____
  _____
- Are you taking blood thinners? Yes _____ No_____
- Are you diabetic? Yes ____ No ____