CENTRAL ILLINOIS HEARING, LTD.

ADULT CASE HISTORY

****Please use black ink****

Name _____Birthdate _____ Referred by _____

- 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 _____

- 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 or stuffiness in yours ears? Yes _____ No _____

- Do you ever experience facial numbness, weakness or tingling? Yes _____ No _____

- Are you ever dizzy? Yes _____ No _____
  If yes, is your dizziness accompanied by Nausea? Yes _____ No _____
  Vomiting? Yes _____ No _____
  Noises in your ears? Yes _____ No _____

- Are you ever unsteady? Yes _____ No _____

- Are you ever off balance/have falls? 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 ____
  Please list or provide attachment_____
  _____

- Are you taking blood thinners? Yes _____ No _____

- Do you have a history of depression? Yes ____ No ____
  If yes, are you taking any medication for depression? Yes ____ No ____

- Are you diabetic? Yes _____ No _____

Date: _____ **Signature** _____