Hearing & Balance Clinic

Adult Case History Form

For Office Use Only
Scanned By: _____
Processed By: _____
Provider: _____

Please complete this form. Attach copies of any additional information or reports that might assist our evaluation

Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____
Street/PO BOX City State Zip Code

Email: _____ Cell Phone: _____ Home Phone: _____

1. Describe your chief complaint or reason for referral: _____
2. Have you had your hearing evaluated previously? ☐ Yes ☐ No
   If so, what were the results? _____
3. Do you have hearing loss? ☐ Yes ☐ No If so, which ear? ☐ Right ☐ Left ☐ Both
   When did it begin? _____ Has it become worse? ☐ Yes ☐ No
   Was the onset sudden or gradual? _____
   Describe situations where you have a hard time understanding speech: _____
   _____
   _____
4. Have you used a hearing aid previously? ☐ Yes ☐ No
   If so, which ear? ☐ Right ☐ Left ☐ Both What type of device? _____
   How long did you use it? _____ How did it benefit you? _____
5. Is there family history of hearing loss? ☐ Yes ☐ No
   If yes, who had hearing loss? _____ What was the age it began? _____
6. Have you had a history of loud noise exposure? ☐ Yes ☐ No
   Where were you exposed? ☐ Work ☐ Military ☐ Hobbies (woodworking, music, shooting, etc.)
   Did/do you wear ear protection? ☐ Yes ☐ No
7. Do you hear noise, ringing, or buzzing in the ears? ☐ Yes ☐ No
   If yes, which ear? ☐ Right ☐ Left ☐ Both
   Describe how it sounds: _____
8. Have you had surgery on your ears? ☐ Yes ☐ No
   What type of surgery? _____ When was the surgery? _____
   Who performed the surgery? _____

9. Have you had an ear injury? ☐ Yes ☐ No

   If so, please describe _____

10. Have you had ear infections? ☐ Yes ☐ No If so, What ear? ☐ Right ☐ Left ☐ Both

    What age did they begin? _____ How many have you had? _____

    When was the last infection? _____ What type of treatment have you had? _____

11. Do you ever experience episodes of dizziness, vertigo, or car sickness? ☐ Yes ☐ No

    If yes, please describe _____

12. Please Check (✓) if you have experienced any of the following:

□ Heart Disease	□ Mumps	□ Kidney or renal problems	□ Stroke/ITA
□ Meningitis	□ Chronis sinus infections	□ Diabetes	□ Measles
□ Allergies	□ High Blood Pressure	□ Scarlet Fever	□ Cancer
□ Hypothyroidism	□ Radiation/chemotherapy	□ Asthma	□ Tuberculosis
□ IV antibiotics	□ Mental Illness	□ Visual Problems	□ Head Trauma
□ Depression/Anxiety	□ Hepatitis A, B, or C	□ Loss of Consciousness	□ Migraines
□ Liver Problems	□ Exposure to chemicals/solvents		

13. Please check (✓) if you have **<u>experienced</u>** any of the following:

□Excessive Ear Wax	□Ear Drainage/Bleeding	□ Ear Pressure/Fullness	□Swimmers' Ear
□Popping Sensation in the Ear		□ Fluctuating hearing loss	□ Ear Pain
□Dizziness/Vertigo	□Fluid Behind the Eardrum	□ Sensitivity to Loud Noises	

14. Please check (✓) if you have been **<u>diagnosed</u>** with any of the following:

□ Otosclerosis	□ Cholesteatoma	□ Sudden Hearing Loss	□ Labyrinthitis
□ Meniere's Disease	□ Barotrauma	□ Permanent Hearing Loss	□ Bell's Palsy
□ Ossicular Dislocation/Fixation		□ Acoustic Neuroma	

15. Please list all current OTC and prescription medications include frequency and dosages:

    1_____

    2_____

    3_____

    4_____

    5_____

    If needed, list additional medications on separate sheet of paper.

Signature: _____ Date: _____