AUDIOLOGY CLINIC: ADULT CASE HISTORY FORM

Client Name: _____________________________ Age: ____ Date of Birth: ___________
Occupation: __________________________________________ Preferred Pronoun: _____________
Referred by: __________________________________________

1. Reason for visit: __________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

2. Previous hearing evaluations: Yes No
   Where: __________________________________________
   When: __________________________________________
   What were the results? __________________________________________
   What were the recommendations? ________________________________

3. Hearing loss: Yes No
   If YES, which ear? Right Left Both
   Is one ear better than the other? If YES, which? Right Left
   When did the hearing loss begin/age of onset? ________________________________
   Did the loss occur SUDDENLY or GRADUALLY? ________________________________
   Has it gotten worse? Yes No
   Comments: ____________________________________________________________________

Person completing form: ____________________________ If not client, relation to client: ____________

Signature Date

08/29/2019
4. Do you have difficulty in any specific listening situations?  
   If YES, check all that apply:
   - [ ] Using the telephone
   - [ ] Women and children’s voices
   - [ ] Quiet conversation (one-to-one)
   - [ ] In the presence of background noise
   - [ ] In groups of people
   - [ ] Watching television
   - Other: ________________________

5. Do you have any family members that had hearing loss before age 50?  
   If YES, check all that apply:
   - [ ] Using the telephone
   - [ ] Women and children’s voices
   - [ ] Quiet conversation (one-to-one)
   - [ ] In the presence of background noise
   - [ ] In groups of people
   - [ ] Watching television
   - Other: ________________________

6. Do you hear ringing, buzzing, or other head noises?  
   If YES, which ear? ________________________
   Is it CONSTANT or INTERMITTENT? ________________________
   Rate the severity on a scale of 1 to 5, 1 being minimal and 5 being unbearable:

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7. Do you have a history of ear pain, drainage or ear infections?  
   If YES, which ear? ________________________
   When did this occur? ________________________
   What were the symptoms? ________________________
   How was it treated? ________________________

8. Do you have a history of ear surgery?  
   If YES, which ear? ________________________
   Date(s) of surgery? ________________________
   What type(s) of surgery? ________________________

9. Do you have a history of dizziness?  
   If YES, how would you describe your dizziness? ________________________
   When did it start? ________________________
   What brings it on? ________________________
   How often does it occur? ________________________
   Has medical consultation been obtained?  
   Comments: ________________________
10. Do you have a history of head trauma?  
   Yes  No  
   (EX. Skull fracture, concussion, unconsciousness)  
   If YES, please describe, including dates and circumstances  
   ____________________________________________________________________________

11. Do you have a history of other health problems?  
   Yes  No  
   (EX. diabetes, kidney, circulatory/heart, thyroid, infections, etc.)  
   If YES, please describe: ____________________________________________________________________________

12. Do you currently take medications?  
   Yes  No  
   If YES, please list below (name, description, dosage, route):  
   ____________________________________________________________________________  
   ____________________________________________________________________________  
   ____________________________________________________________________________  
   ____________________________________________________________________________  
   ____________________________________________________________________________  
   ____________________________________________________________________________  
   To your knowledge, have you ever taken a medication that might have affected your hearing?  
   Yes  No  
   Please describe: ____________________________________________________________________________

13. Do you have a history of noise exposure?  
   Yes  No  
   (EX. Armed services, work, recreation, etc.)  
   If YES, please list and describe where it occurred: ____________________________________________________________________________  
   How many years exposed? ______  How many hours exposed per day? ______  
   Was hearing protection worn? _____  When was your most recent exposure to noise? ______

14. Have you ever worn or trialed hearing aids?  
   Yes  No  
   If YES, which style? (BTE, RITE, ITE, ITC, CIC)  
   Ear Fitted:  
   Right  Left  Both  
   When obtained: ______  Where obtained: __________  Period Worn: ______  
   Benefit/limitations: ____________________________________________________________________________  
   Additional Comments: ____________________________________________________________________________
15. What are your greatest hearing concerns related to work, daily activities, etc.? 

______________________________________________________________________________
______________________________________________________________________________

OTHER PERTINENT INFORMATION: 

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________