WESTERN WASHINGTON UNIVERSITY

An equal opportunity university

Communication Sciences and Disorders

Bellingham, Washington 98225-9171
(360) 650-3881 Fax (360) 650-4334

Person completing form: _____ ***If not client, relation to client:*** _____

_____

Signature ***Date***

AUDIOLOGY CLINIC: ADULT CASE HISTORY FORM

Client Name: _____ Age: ____ Date of Birth: _____
Occupation: _____Preferred Pronoun: _____
Referred by: _____

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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: _____
   _____

4. Do you have difficulty in any specific listening situations? Yes No

   If YES, check all that apply:

   [] Using the telephone
   [] Quiet conversation (one-to-one)
   [] In groups of people
   [] Watching television
   [] Women and children's voices
   [] In the presence of background noise
   [] Other: _____

5. Do you have any family members that had hearing loss before age 50? Yes No

   If YES, what is their relationship to you? _____

6. Do you hear ringing, buzzing, or other head noises? Yes No

   If YES, which ear? Right Left Both

   Is it CONSTANT or INTERMITTENT? _____

   Rate the severity on a scale of 1 to 5, 1 being minimal and 5 being unbearable:

   1 2 3 4 5

7. Do you have a history of ear pain, drainage or ear infections? Yes No

   If YES, which ear? Right Left Both

   When did this occur? _____

   What were the symptoms? _____

   How was it treated? _____

8. Do you have a history of ear surgery? Yes No

   If YES, which ear? Right Left Both

   Date(s) of surgery? _____

   What type(s) of surgery? _____

9. Do you have a history of dizziness? Yes No

   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? Yes No

   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: _____
_____
_____
_____
_____
_____
_____
_____