

ADULT AUDIOLOGICAL CASE HISTORY

Date _____

Name _____ Sex _____ Birth Date _____

Address _____ Marital Status _____

_____ Home Phone _____

Occupation _____ Business Phone _____

Referral Source _____ Purpose of Test _____

PAST AND PRESENT HEARING STATUS

Description of problem:

Previous hearing tests: Y N

Date of last evaluation: _____

Results:

Best ear: R L Ear used on the phone: R L

When did you notice a hearing loss and was it gradual or rapid?

Pertinent health status at onset:

Fluctuation in hearing: Y N

Describe situations of hearing difficulty: (groups, telephone, TV, radio, loudspeaker, etc.)

Activities limited/stopped due to hearing:

Family history of hearing loss: Y N

Relationship: _____

Factors contributing to hearing loss:

Noise exposure: Y N

Tinnitus: R L Both

Describe: (type, severity, fluctuation, onset, frequency, duration)

Tolerance of loud sound: Y N

Describe the specific sounds that bother you:

Feeling of fullness in ear: R L No

Discharge or pain in ear: R L No

Dizziness: Y N

Describe: (type, frequency, onset, precipitating factors, nausea, vertigo)

Does hearing loss interfere with occupation: Y N
Does tinnitus interfere with occupation: Y N
Does vertigo interfere with occupation: Y N

MEDICAL HISTORY

Middle and external ear problems: Y N

Otological treatment/surgery: Y N

List: _____

Associated and serious illnesses (include onset, duration, mediations):

Ear infections	Respiratory system	Digestive
Headaches	Diabetes	Neurological impairment
Sinus problems	Thyroid	Urinary/Kidney
Sleep disorder	Depression/Anxiety	Bone/Joint
Blood pressure	Reproductive system	

Accidents/head injuries: Y N

Describe: _____

CURRENT HEALTH STATUS

Health status/problems:

Current medications:

HEARING AID USE/REHABILITATION

Currently wear hearing aid(s): Y N

Type: _____ Make/Model: _____ Ear: _____

Length of use (years): _____

Situations where aid most helpful:

Purchased from: _____

Previously worn hearing aid(s): Y N

Describe:

Attitude toward amplification:

Speech Reading/Auditory Training: Y N

Describe:

Speech problems: Y N

Describe:

Person/s other than patient providing information: _____

Additional comments:
