COLUMBUS SPEECH & HEARING
EST.1923

AUDIOLOGY ADULT CASE HISTORY

Name: _____ DOB: _____ Today's Date: _____

GENERAL INFORMATION

1. What is your primary reason for coming in today?

   _____

2. If you suspect a hearing loss, how long have you noticed this problem?

   _____

3. What do you feel is the cause of your hearing loss?

   _____

4. Was the onset gradual or sudden?

   _____

5. In which ear do you hear the best? ☐ Right ☐ Left ☐ Same in both ears

6. Is your hearing better some days than others? ☐ YES ☐ NO

7. Have you ever been exposed to occupational or recreational noise? ☐ YES ☐ NO
   (Ex: military, music, gunfire)

   If yes, please describe:

   _____

8. Does anyone in your family have hearing loss? ☐ YES ☐ NO

   If so, who?

   _____

9. Have you ever had your hearing tested? ☐ YES ☐ NO

   If yes, when?

   _____

10. What were the results?

    _____

11. Have you seen a physician for your hearing? ☐ YES ☐ NO

    If yes, when and where?

    _____

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MEDICAL

1. Have you had earaches or drainage from your ears within the last 90 days? ☐ YES ☐ NO
2. Have you ever had medical/surgical treatment for your ears? ☐ YES ☐ NO
   If yes, at what age?

   _____
3. Do you ever have dizziness, balance problems or falls? ☐ YES ☐ NO
4. Do you notice any tinnitus (i.e., ringing, buzzing or roaring) in your ears? ☐ YES ☐ NO
   If yes, which ear? ☐ Right ☐ Left ☐ Same in both ears
   How frequent?

   _____
5. Is it bothersome? ☐ YES ☐ NO
   Please describe the sound you hear:

   _____
6. Please list any medications (including nonprescription) you are currently taking or have taken recently:

   _____
7. Do you have any open sores, bleeding or drainage at this time? ☐ YES ☐ NO

Have you ever had any of the following?

☐ Arthritis ☐ Allergies ☐ Bell's Palsy

☐ Cancer (Type/Treatment): _____

☐ Concussion/Skull Fracture	☐ Dementia/Alzheimer's	☐ Depression/Anxiety	☐ Diabetes Type I
☐ Diabetes Type II	☐ Hepatitis	☐ High Blood Pressure	☐ High Fevers
☐ HIV	☐ Measles	☐ Meningitis	☐ Multiple Sclerosis
☐ Mumps	☐ Pacemaker	☐ Parkinson's	☐ Scarlet Fever
☐ Seizures	☐ Stroke/TIA	☐ Tuberculosis	☐ Vision Problem

HEARING HISTORY

Do you have difficulty hearing/understanding during any of the following activities?

☐ Watching TV	☐ Telephone	☐ Restaurants	☐ Movies
☐ Meetings	☐ Worship Service		

Do you have trouble hearing a:

☐ Telephone Ring	☐ Fire/Smoke Detector	☐ Doorbell	☐ Siren
☐ Alarm Clock	☐ Baby Cry		

List the three areas where you have the most difficulty hearing or understanding:

_____

_____

_____

Which ear do you use on the telephone? ☐ Right ☐ Left

Are you left- or right-handed? ☐ Right ☐ Left

Is there any other information related to your hearing you feel might be important for the audiologist to know?

_____

HEARING AID HISTORY

1. Have you ever worn a hearing aid? ☐ YES ☐ NO
2. Do you use a hearing aid now? ☐ YES ☐ NO

   If yes, how long have you had a hearing aid?

   _____
3. On which ear do you use the hearing aid? ☐ Right ☐ Left
4. Do you wear it regularly? ☐ YES ☐ NO
5. Do you feel you benefit from it? ☐ YES ☐ NO
6. List any problems you are having with the hearing aid:

   _____
7. What would you improve with your current hearing aid?

   _____

Whom should we thank for referring you to CSHC?

☐ Primary Physician ☐ Family/Friend ☐ Senior Options

☐ Other _____