HEARING
LISTENING
TINNITUS
HYPERACUSIS

SOUND id·EARS CLINIC

ADULT CASE HISTORY FORM

Date:	Age:
Name:	

What is your chief complaint?

☐ Hearing loss (☐ Right ☐ Left) ☐ Difficulty Hearing (☐ In quiet ☐ in noise)
☐ Telephone (☐ Right ☐ Left) ☐ Tinnitus/Ringing ☐ Dizziness

How long have you noticed this difficulty?	
Is this problem due to a work-related injury/exposure? If so:	☐ Yes ☐ No Date of Injury: Explain:
Do you feel your hearing is changing?	☐ Yes (☐ Gradual ☐ Sudden) ☐ No

Have you ever been exposed to loud noise, either recently or in the past? ☐ Yes ☐ No

If so, mark all that apply:

☐ Farm Machinery ☐ Military ☐ Factory Noise
☐ Music ☐ Jet Engines ☐ Other:
☐ Power Tools ☐ Hunting/Shooting

Have you seen an Ear, Nose, and Throat (ENT) Physician? If so, who did you see? When?	☐ Yes ☐ No Name: Date:
Have you had surgery that may have affected your hearing?	☐ Yes ☐ No
Is there a history of hearing loss in your family? If so, who?	☐ Yes ☐ No Relation:
Have you ever had an ear infection?	☐ Yes (☐ As a child ☐ As an adult) ☐ No
Have you, in the past 10 years, experienced dizziness, light-headedness, or vertigo?	☐ Yes ☐ No If yes, describe:

Do you take any prescription medications on a regular basis? Please list:

Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____

Please check any of the following that your currently have or have had in the past:

☐ Arthritis ☐ Heart Trouble ☐ Measles ☐ Pacemaker ☐ Stroke/TIA
☐ Asthma ☐ Hepatitis ☐ Meningitis ☐ Parkinson's ☐ Visual Loss/Sight
☐ Bell's Palsy ☐ High Blood Pressure ☐ Mumps ☐ Scarlet Fever ☐ Neurological Symptoms
☐ Diabetes ☐ Malaria ☐ HIV ☐ Head Injury

Please rank the following in order of importance (1=most important; 4=least important) **if a hearing aid is recommended for you:**

____ Improved hearing in quiet
____ Improved hearing in noise
____ Cosmetic appearance
____ Expense

If you are currently using a hearing aid, or have in the past, please answer the following:

Which ear is/was aided? ☐ Right ☐ Left
How long have you used a hearing aid?
What would improve your current hearing aid?

If you think you have hearing loss, please answer the following:

Will this be your first hearing test?	○ Yes ○ No
Have you noticed that people seem to mumble?	○ Yes ○ No
Do you find yourself asking people to repeat what they have said?	○ Yes ○ No
Do you sometimes hear words but you don't always understand them?	○ Yes ○ No
Do you find it difficult to hear in noisy places?	○ Yes ○ No
Have you been told that you speak loudly?	○ Yes ○ No
Do you find it difficult to understand speech when your back is to the speaker?	○ Yes ○ No
Do others complain that the TV is too loud?	○ Yes ○ No
Have you been told that you have missed the ringing of a telephone?	○ Yes ○ No
Do you find it difficult to hear when using the telephone?	○ Yes ○ No
Do you avoid social events because of your hearing difficulty?	○ Yes ○ No
Do you know the cause of your hearing loss?	○ Yes ○ No
How did your hearing loss develop?	○ Suddenly ○ Gradually

If you use a hearing aid, please answer the following questions:
(While wearing you hearing aid)

I can hear but I have difficulty understanding	○ Yes ○ No
I have difficulty understanding when two or more are talking	○ Yes ○ No
I have difficulty understanding when in a crowd	○ Yes ○ No
I have difficulty understanding at a distance	○ Yes ○ No
I have difficulty knowing from which direction sounds are coming	○ Yes ○ No
I have difficulty while using the telephone	○ Yes ○ No
My own voice sounds hollow and unnatural	○ Yes ○ No
Words often run together	○ Yes ○ No
My hearing aid(s) don't make the sounds loud enough	○ Yes ○ No
Some sounds are too loud	○ Yes ○ No
My hearing aid(s) make sounds tinny	○ Yes ○ No
My hearing aid(s) whistles	○ Yes ○ No
My hearing aid(s) makes my ear sore	○ Yes ○ No