ADULT HEARING CASE HISTORY

NAME:_____**DATE** ___/___/___

WHO REFERRED YOU TO US? _____

WHO IS YOUR FAMILY DOCTOR? _____

Please check "yes", or "N/A" (Not Applicable) to the following questions.

	YES	NO	N/A	
Do you have a hearing problem?	___	___	___	**Which Ear?** _____
Is one ear better than the other?	___	___	___	**Which One?** _____
Did your hearing loss come about suddenly?	___	___	___	**When?** _____
Does your hearing loss "come and go" (fluctuate)	___	___	___	**How Often?** _____
Do you have trouble hearing speech?	___	___	___	**Only in Noise?** _____
Do you have "ringing or roaring" in your ears?	___	___	___	**Which Ear?** _____
Do you have "dizziness or black out spells"?	___	___	___	**How Often?** _____
Do you wear a hearing aid?	___	___	___	**Which Ear?** _____

Where did you get your hearing aid?_____

Do you or have you worked in loud noise?	___	___	___	**Where?** _____
Do you or have you had any noisy hobbies?	___	___	___	**What Hobby?** _____
Does anyone in your family have hearing loss?	___	___	___	**Who?** _____

OVER

Please complete the other side of this form

DO YOU HAVE or HAVE YOU HAD ANY OF THE FOLLOWING AND WHEN

	YES	NO	WHEN
Pressure of fullness in the ears (Ears feel stopped up)?	____	____	_____
High Blood Pressure?	____	____	_____
Stroke?	____	____	_____
Heart Attack?	____	____	_____
Circulation Problems?	____	____	_____
Diabetes?	____	____	_____
Thyroid Problems?	____	____	_____
Cancer?	____	____	_____
Arthritis?	____	____	_____
Low-Blood Sugar?	____	____	_____
Recent Ear Infection?	____	____	_____
Ruptured or Burst Eardrum?	____	____	_____
Drainage from your Ears?	____	____	_____
Ear Surgery?	____	____	_____
Head or Neck Surgery?	____	____	_____
Skull Fracture or Brain Concussion?	____	____	_____
Frequent or Severe Headaches?	____	____	_____

Do you want a copy of your test results and report sent to anyone or any agency?_____ If so, to whom?_____

COMMENTS:_____
_____
_____
_____