COLUMBUS SPEECH&HEARING CENTER
We Improve Communication for Life

Audiology
Adult Case History

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

GENERAL

What is your primary reason for coming in today? _____

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

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

Was the onset gradual or sudden? _____

In which ear do you hear the best? □ Right □ Left □ Same in both ears

Is your hearing better some days than others? □ YES □ NO

Have you ever been exposed to occupational or recreational noise? (Ex: military, music, gun fire)

□ YES □ NO

If yes, please describe: _____

Does anyone in your family have hearing loss? □ YES □ NO

If so, who? _____

Have you ever had your hearing tested? □ YES □ NO

If yes, when? _____

What were the results? _____

Have you seen a physician for your hearing? □ YES □ NO

If yes, when and where? _____

MEDICAL

Have you had earaches or drainage from your ears within the last 90 days? □ YES □ NO

Have you ever had medical/surgical treatment for your ears? □ YES □ NO

If yes, at what age? _____

Do you ever have dizziness, balance problems, or falls? □ YES □ NO

Do you notice any tinnitus (for example: ringing, buzzing, or roaring) in your ears? □ YES □ NO

If yes, which ear? □ Right □ Left How frequent? _____

Is it bothersome: □ YES □ NO

Please describe the sound you hear: _____

Please list any medications (including non-prescriptions) you are currently taking or have taken recently: _____

_____

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 in any of the following activities?

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

Do you have trouble hearing a:

□ Telephone ring □ Doorbell □ Alarm Clock
□ Fire/smoke detector □ Siren □ Baby cry

List 3 areas where you have the most difficulty hearing or understanding:

1. _____
2. _____
3. _____

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

Have you ever worn a hearing aid? □ YES □ NO

Do you use a hearing aid now? □ YES □ NO

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

On which ear do you use the hearing aid? □ Right □ Left

Do you wear it regularly? □ YES □ NO

Do you feel you benefit from it? □ YES □ NO

List any problems you are having with the hearing aid: _____

_____

What would you improve with your current hearing aid? _____

_____

Whom should we thank for referring you to CSHC? _____

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