Sacred Heart UNIVERSITY *Audiology Clinic*

Adult Case History

Name: _____ Date of Birth: ___/___/___ Today's Date: ___/___/____

Reason for Today's visit _____

Referred by _____

GENERAL MEDICAL

1. Have you had any of the following:

Kidney Disease…….. YES ☐ NO ☐ Hypertension…… YES ☐ NO ☐
Diabetes…….. YES ☐ NO ☐ Visual problems……... YES ☐ NO ☐
Cancer…… YES ☐ NO ☐ Sinus problems…… YES ☐ NO ☐
Other (please list)

2. Are you taking any **medications**? YES ☐ NO ☐
IF YES, which ones _____

3. Have you ever experienced **head trauma**? YES ☐ NO ☐ _____
4. Have you ever had surgery on your ear(s), nose, or throat? YES ☐ NO ☐

HEARING (*Please fill in the blanks or check where appropriate*)

1. When did you **first** notice your hearing problem? _____

2. Was your **change in hearing** SUDDEN or GRADUAL? _____

3. Has your hearing become **worse** since you first noticed the problem? ☐ NO ☐ YES
4. Do you hear **better in one ear** than the other? YES ☐ NO ☐
   If **YES**, which ear is **better**? RIGHT ☐ LEFT ☐

5. Does your hearing remain CONSTANT or FLUCTUATE? _____

6. Have you experienced any of the following:

YES ☐ NO ☐ **Ear pain** **If Yes:** RIGHT ☐ LEFT ☐ BOTH ☐
YES ☐ NO ☐ **Plugged ear(s)** **If Yes:** RIGHT ☐ LEFT ☐ BOTH ☐
YES ☐ NO ☐ **Ringing/buzzing** **If Yes:** RIGHT ☐ LEFT ☐ BOTH ☐
YES ☐ NO ☐ **Dizziness/Vertigo**

8. Have you ever been exposed to loud noise (work, recreation, Military service)? YES ☐ NO ☐
   IF YES, please briefly explain _____

9. Has anyone in your family experienced hearing loss? YES ☐ NO ☐
   If YES, who? _____

10. Have you had your hearing tested before? YES ☐ NO ☐

11. Have you ever worn hearing instruments? YES ☐ NO ☐ Currently? YES ☐ NO ☐

12. Which situations do you have difficulty hearing? _____