Comprehensive Case History

Name: _____Date:_____ Date of Birth: _____ M / F

Audiologic History

Do you experience hearing loss? Yes No If so, which ear? Right Left Both
If you experience hearing loss, which best describes it? Gradual Fluctuating Sudden
When did you first notice your hearing loss?: _____
What do you think is the cause of your hearing loss?: _____
Have you ever had a hearing test? Yes No If so, when? _____ _____
Which ear do you use to talk on the phone: Right Left

Please check all medical conditions that apply:

____ Developmental Disorders/Delays: Explain _____
_____ Dizziness or Unsteadiness
_____Have you fallen within the past year? If so, how many times? _____ With injury? Yes / No
_____ Ear Deformity: Right ear Left ear Both ears
_____ Ear Drainage: Right ear Left ear Both ears
_____ Ear Pain: Right ear Left Ear Both ears
_____ Family History of Hearing Loss: Who? _____
_____ History of Ear Infections Right ear Left ear Both ears Last infection: _____
_____ History of Ear Wax Buildup
_____ History of Noise Exposure: Work or Recreational? Describe _____
_____ Previous Ear Surgery Right ear Left ear Both ears When?_____
_____ Tinnitus/Ringing/Noises in ears: Right ear Left ear Both ears Frequency?_____
Are your current symptoms Acute / Chronic / Progressive / Fluctuating / Sudden (Please circle one)

Medical History

Any other illnesses, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence:

_____
_____

Have you experienced any of the following major medical conditions (please check all that apply)

_____ AIDS/HIV
_____Mumps
_____Diptheria
_____High Blood Pressure
_____Appetite Change
_____Encephalitis
_____High Fevers
_____Scarlet Fever
_____Arthritis
_____Fatigue
_____Influenza
_____Stroke
_____Blood Disorders
_____Genetic Disorders
_____ Meningitis
_____ Vascular Problems
_____ Heart Problems
_____ Diabetes
_____ Measles
_____ Head Injury
_____ Chicken Pox
_____ Typhoid
_____ Malaria
_____ Headaches
_____ Cancer
_____Tonsillitis
_____Allergies (Food, medications, plastics)
_____Other _____

Please check all medical symptoms that apply:

_____ Eye Problems (such as blurred vision, pain)
_____ Nose, Throat, or Mouth Problems
_____ Cardiovascular Problems
_____ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma)
_____ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness)
_____ Psychiatric Issues (such as depression, anxiety, compulsions)
_____ Kidney Problems
_____ Hematologic/Lymphatic Symptoms (such as bleeding gums, bruising)
_____ Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency)
_____ Smoke / If so, how often? _____Did you quit over 1 year ago? Yes / No
_____ Exposed to Second Hand Smoke
_____ Alcohol ____ Daily ____ Weekly ____ Occasionally
_____ Caffeine

Current Medications (over the counter and prescriptions):

Name of the Drug: Dosage: Frequency: How is it administered?

_____

_____

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Please answer the following questions:

Does a hearing problem cause you to feel embarrassed when you meet new people?
Yes Sometimes No

Does a hearing problem cause you to feel frustrated when talking to members of your family?
Yes Sometimes No

Do you have difficulty when someone speaks in a whisper?
Yes Sometimes No

Do you feel handicapped by a hearing problem?
Yes Sometimes No

Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
Yes Sometimes No

Does a hearing problem cause you to attend religious services less often than you would like?
Yes Sometimes No

Does a hearing problem cause you to have arguments with family members?
Yes Sometimes No

Does a hearing problem cause you difficulty when listening to TV or radio?
Yes Sometimes No

Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
Yes Sometimes No

Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
Yes Sometimes No

What is your hearing aid experience? ___ N/A

___ I have hearing aids and use them regularly.

___ I have hearing aids, but don't use them.

___ I tried hearing aids, but was unsuccessful.

___ I have never used hearing aids.

If hearing aids are recommended, how would you rank the following? Please indicate in order what is important to you. ***(1= most important / 5= least important)***

__Service __Appearance ___Sound quality & Clarity ___Handling Ease ___Cost

Please rank the following situations from most important to least important regarding which situations in which you are having difficulty understanding and would like to improve understanding with hearing aids:

(1 = Most important / 10 = Least important)

___Quiet room ___Television ___Music ___Restaurants ___Church

___Meetings ___ Telephone ___Work ___Car ___Social events

On a scale from 1-10 (1=poor: 10=excellent), how well do you think you understand now? _____

How well do you think you will understand with the use of hearing aids?___

If you are a hearing aid user, do you still experience any of the following with your current hearing aid? (please check all that apply)

- ◊ Some sounds are too loud
- ◊ Trouble understanding in noise
- ◊ Wind noise
- ◊ Pain
- ◊ Do not like sound of own voice
- ◊ Feedback or whistling
- ◊ Cleaning hearing aid
- ◊ Battery life
- ◊ Repair issues
- ◊ Trouble understanding in quiet
- ◊ Sounds are too soft
- ◊ Do not like the appearance of aid
- ◊ Trouble using telephone
- ◊ Sounds are tinny or metallic
- ◊ Cannot tell direction of sound
- ◊ Changing battery
- ◊ Naturalness of sound
- ◊ Other: _____

Please add any additional information

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