ADULT CASE HISTORY

Name: _____ DOB: _____ Date: _____

Reason for Visit: _____

1- Are you aware of having hearing loss? ☐ Yes ☐ No

- Was your hearing loss sudden or gradual? ☐ Sudden ☐ Gradual
- Is your hearing loss worse in one ear? ☐ Right ☐ Left

2- Do you experience tinnitus (ringing in the ears/head)? ☐ Yes ☐ No

Please describe your tinnitus (i.e. how often, how loud, etc…)

_____

3- Have you been exposed to loud noise? ☐ Yes ☐ No

Please describe the noise

_____ ____

4- Do you have family members (blood relatives) with hearing loss? ☐ Yes ☐ No

5- Do you have pain or discomfort in your ears? ☐ Yes ☐ No

6- Have you had drainage from your ears in the past 90 days? ☐ Yes ☐ No

7- Do you have a history of ear infections? ☐ Yes ☐ No

8- Have you seen an Ear, Nose and Throat doctor? ☐ Yes ☐ No

9- Have you had any significant head trauma? ☐ Yes ☐ No

10- Have you taken medication that may be toxic to hearing? ☐ Yes ☐ No

11- Please mark any of the following that you have or that you have had in the past:

☐ Arthritis	☐ Neurological Symptoms	☐ Hepatitis B
☐ Cancer	☐ Parkinson's	☐ HIV
☐ Chemotherapy	☐ High Blood Pressure	☐ Sinusitis
☐ Radiation	☐ Dementia/Cognitive Decline	☐ Measles
☐ Diabetes	☐ Significant Vision Impairment	☐ Meningitis
☐ Stroke/TIA	☐ Cardiovascular Disease	☐ Other

12- Please list any medication you are taking:

13- Are you taking a blood thinner or aspirin? ☐ Yes ☐ No

14- Who or what do you have the most difficulty hearing?

_____

15- Who or what would you most like to hear better?

_____

16- Are you aware of the connection between hearing loss and dementia? ☐ Yes ☐ No

17- Please rate your hearing level:

Very Poor	1	2	3	4	5	6	7	8	9	10	**Very Good**

18- How important is it for you to hear better?

Not Important	1	2	3	4	5	6	7	8	9	10	**Very Important**

19- How motivated are you to use hearing devices?

Not Motivated	1	2	3	4	5	6	7	8	9	10	**Very Motivated**

20- Have you ever had your hearing tested? ☐ Yes ☐ No

- If yes, when and where _____
- Results _____

21- Do you wear hearing aids? ☐ Yes ☐ No

- If yes, how long have you worn them _____
- What would you like to improve about your current hearing devices?

_____

22- Is there anything else you would like us to know?

_____