ADULT EAR and HEARING CASE HISTORY

Patient Name:______________________________________ Age:_____________

What concerns are you here for today?

______ Hearing Loss ______ Ear Noises ______ Dizziness ______ Other

If other, please specify here:____

On a scale of 1 to 10, one being bad and ten being great, how would you rate your hearing ability? (circle) 1 2 3 4 5 6 7 8 9 10

1. Have you been diagnosed with a hearing loss in the past?

   _____ Yes _____ No

   A. Which ear has a hearing loss? ______Right _____Left ______Both

   B. How long have you known of the hearing loss?_________________

   C. Have you ever worn hearing aids? ______Yes ______No

   D. How long have you worn hearing aids? _______________________

   E. Do you wear one or two hearing aids? ______One _____Two

2. Does one ear hear better than the other?

   _____ Right _____Left _____Neither

3. Did your hearing loss come on: _____ gradually? _______ suddenly?

4. Does anyone in your family have a hearing loss? _____ Yes ____ No

   Who?____

5. Have you ever had ear surgery? _____ Yes ____ No

   A. What for and when?____

6. Do you experience ringing/noises in the ears (tinnitus) on a regular basis?

   _____ Right _____ Left _____Both

   A. How long have you experienced the ringing?______________________

   B. How long does the ringing last when it appears?__________________

   C. Have you discussed this with your physician?_____________________

7. Do you experience ear pain or ear drainage? _____ Yes ______ No

8. Do you have concerns with ear wax build-up? ____ Yes ______ No

9. Do you experience dizziness on a regular basis? ______ Yes ______ No

   A. How often does the dizziness appear?___________________________
   B. How long does the dizziness last when it appears?_________________
   C. Have you discussed this with your physician?_____________________
   D. Do you take medication to help the dizziness?_____________________

10. Have you been exposed to loud noises for prolonged periods of time or repeatedly?(examples include: firearms, farm machinery, lawn mowers, vacuums, factory work, construction tools, or woodworking tools)

    ______ Yes ______ No

    If **yes**, Do/Did you wear hearing protection? ______ Yes ______ No
    If **yes**, what percentage of time do/did you wear the hearing protection?

    ______ 1-25% ______ 26–50% ______ 51-75% ______ 76-100%

11. Do you experience allergies? ______ Yes ______ No

    A. Do you take daily allergy medication? ______ Yes ______ No
    B. How are your sinuses today?

    ______ Clear ______ Mostly Clear ______ Mostly Congested ______ Congested

12. Have you had or do you have the following?:
    Diabetes:_______________ High or Low Blood Pressure:__________
    Memory Loss:___________ Stroke:_________________
    Heart Attack with a pacemaker:___________________

Please list medications here:____

____

____

Who referred you to Advanced Audiology, LLC?_____________________________

By signing below you verify the above information is accurate and you authorize Advanced Audiology, LLC to perform testing, care and management services relating to your hearing health care needs.

_______________________________________ ______________________

Patient Signature Date

_______________________________________ ______________________

Witness Signature Date