Comprehensive Case History Form

Patient's Name: _____ **Date of Completion:** _____

Date of Birth: _____ **Gender:** Male or Female **Primary Language:** _____

Status Marital: Single Married Divorced Widowed Domestic Partner

Race: White African-American Asian American Indian Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Current Employment: Full-time Part-time Retired Unemployed Stay at Home Parent Student

Current Employer: _____ **Position:** _____

Highest Level of Education: _____

Do you currently use recreational drugs?: Yes No

If yes, what drugs and how often: Daily Weekly Monthly Occasionally Rarely

Do you currently use tobacco?: Yes No

If yes, what do you smoke: Cigarettes Cigars Pipe Smokeless Other: _____

If yes, amount per day: _____

Do you currently drink alcoholic beverages?: Yes No

If yes, how often: Daily Weekly Monthly Occasionally Rarely

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

Have you ever worn or tried a hearing aid? Right Ear Left Ear Both Ears

What type and/or style of hearing aid: _____

Please describe your experience: _____

Do you still experience any of the following with your current hearing aid (please check all that apply):

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

Please check all medical conditions that apply:

_____ **Developmental Disorders/Delays** *If checked, please explain:* _____

_____ **Dizziness or Unsteadiness** *If checked, is it accompanied by: Vomiting Nausea Ear Noises*

_____ **Ear Deformity** *If checked, Right ear Left Ear Both ears*

_____ **Ear Drainage** *If checked, Right ear Left Ear Both ears*

_____ **Ear Pain** *If checked, Right ear Left Ear Both ears*

_____ **Family History of Hearing Loss** *If checked, who?* _____

_____ **History of Ear Infections** *If checked, Right ear Left Ear Both ears If so, when?* _____

_____ **History of Ear Wax Buildup**

_____ **History of Noise Exposure** *If checked, please describe?* _____

_____ **Previous Ear Surgery** *If checked, Right ear Left Ear Both ears If so, when?* _____

_____ **Tinnitus/Ringing/Noises in ears** *If checked, Right ear Left Ear Both ears Frequency?* _____

_____ **Other:** *Please describe:* _____

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

Medical History

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

_____

_____

Allergies (food, medications, plastics, etc.): _____

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

_____ **AIDS/HIV**	_____ **Diphtheria**	_____ **High Blood Pressure**	_____ **Mumps**
_____ **Appetite Change**	_____ **Encephalitis**	_____ **High Fevers**	_____ **Scarlet Fever**
_____ **Arthritis**	_____ **Fatigue**	_____ **Influenza**	_____ **Stroke**
_____ **Blood Disorders**	_____ **Genetic Disorders**	_____ **Malaise**	_____ **Tonsillitis**
_____ **Cancer**	_____ **Headaches**	_____ **Malaria**	_____ **Typhoid**
_____ **Chicken Pox**	_____ **Head Injury**	_____ **Measles**	_____ **Vascular Problems**
_____ **Diabetes**	_____ **Heart Problems**	_____ **Meningitis**	_____ **Other: _____**

Current Medications (over the counter and prescriptions): _____

_____

Have you been immunized? Yes No

If yes, for what illnesses or diseases: _____

Please check all medical symptoms that apply:

- **Eye Problems (such as blurred vision, pain):** Yes No
- **Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain):** Yes No
- **Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations):** Yes No
- **Respiratory Symptoms (such as shortness of breath, cough, wheezing):** Yes No
- **Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain):** Yes No
- **Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma):** Yes No
- **Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness):** Yes No
- **Psychiatric Issues (such as depression, anxiety, compulsions):** Yes No
- **Endocrine Symptoms (such as frequent urination, hot flashes):** Yes No
- **Hemotologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands):** Yes No
- **Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency):** Yes No

Comments Related to Review of Symptoms: