THE HEARING GROUP
OF NEW MEXICO

AUDIOLOGY ADULT CASE HISTORY

Name: DOB: Date

1. Do you think you have a hearing problem? Yes____ No_____
   If so, which ear? Right_____ Left_____Both_____Don't Know_____
2. Was the hearing loss gradual or sudden in onset? Gradual____Sudden_____
3. Have you seen a doctor regarding your hearing loss? Yes____ No_____
4. Have you ever worn hearing aids? Yes____ No_____
   If so, which ear? Right_____ Left_____ Both_____
   When did you get your present hearing aids? Date_____
   How long have you been wearing your hearing aids? _____
5. Are you interested in using a hearing aid? Yes____ No_____
6. Do you have a family history of hearing loss? Yes____ No_____
   If yes do you know what caused the loss? Yes____ No_____
   If yes, explain_____

_____

7. Do you ever experience tinnitus (ear noises)? Yes____ No_____
8. Please rate your tinnitus: Mild____Moderate____Severe____
9. Do you consider your tinnitus to be: Continuous_____Intermittent_____
10. Do you ever experience dizziness/ vertigo? Yes____ No_____
    If yes do you feel nauseous when dizzy Yes____ No_____
11. Do you ever experience ear pain? Yes____ No_____
12. Have you ever had ear surgery? Yes____ No_____
13. Have you ever been exposed to very loud sounds? Yes____ No_____
14. Please list your present/ previous occupation: _____

_____

15. Are you scheduled to see an Ear, Nose, & Throat physician? Yes____ No_____

If yes, please list the name of the ENT physician and date of appointment:

Name of ENT:_____Date_____

Please turn sheet over and complete the other side.

16. Have you had your hearing tested before? Yes_____ No_____

If yes, Name and Address of Clinic/ Audiologist: _____

_____

_____Last date Tested _____

17. List any medications taken regularly: _____

_____

18. Check any illnesses that you have had and a brief description of the illness i.e. your age at the time, mild or severe.

Diabetes_____ If yes, explain_____

_____

Heart Problems_____If yes, explain_____

_____

Meningitis____If yes explain_____

_____

High Blood Pressure____If yes, explain_____

_____

Ear Infections____ If yes, explain_____

_____

Mumps_____If yes, explain_____

Accident____ If yes, explain_____

_____

Head Injury_____If yes, explain_____

_____

Other_____

_____

_____