

Adult Case History Form

Patient Name _____

Birth date _____

What is your primary concern for today's visit? _____

How would you rate your hearing? Circle one: Excellent Good Fair Poor

When did you first notice hearing difficulty? _____

Do you know what caused your hearing loss? _____

Did your hearing loss occur suddenly? No Yes

Does your hearing fluctuate? No Yes

Is one ear better than the other? No Yes: Right Left

Do you hear buzzing, ringing, or other noises in your ears? No Yes

 If YES, is the noise constant? No Yes

 Which ear do you hear it in? Right Left Both

 How bothersome is it? None Slight Moderate Severe

Do you feel any pressure or fullness in your ears? No Yes: Right Left Both

Do you experience any ear pain? No Yes: Right Left Both

Do you have drainage from your ears? No Yes

Do you experience dizziness, vertigo or balance concerns? No Yes

 If YES, is it constant? No Yes

 When did it begin? _____

 Have you fallen in the past 6 months (due to dizziness, imbalance, etc.)? No Yes

Do you have any current or past exposure to loud noise? No Yes

 If YES, circle any that apply: Work Military Power tools Hunting/Shooting
 Motorcycles Loud Music Other: _____

Do you use hearing protection around hazardous noise? No Yes

Please circle any that apply currently or in the past:

High blood pressure Heart disease Diabetes Ear wax problems

History of ear infections Ear surgery Significant vision loss Family history of hearing loss

Allergies/sinusitis Cancer Memory loss concern Head injury

COVID diagnosis Tobacco use (in past 24 months)

Other chronic medical conditions: _____

Do you currently wear hearing aids? No Yes

How Long? _____ Which ear? Right Left Both

*Please list any medications taken on a regular basis **on back of form.** →*

Signature patient/parent or guardian (please circle)

Date

Patient Medication Information

Name: _____

DOB: _____

DATE: _____

Please list all medications below.

(Including Over the Counter/Vitamins/Herbal Supplements)

Medication	Dosage/Strength	Frequency	Route of administration (oral, injection, etc.)

Reviewed by:

Clinician

Date
