Adult Case History Form

Patient Name ____ **Age** _________________ **Date** ____________________

1. Chief complaints: ______ Difficulty Hearing or Understanding (Right/Left/Both) ______Ear Fullness, Pressure or Pain

   _____ Difficulty Hearing on Telephone _____Dizziness/Vertigo _____Tinnitus (Ringing or Buzzing) (Right/Left/Both)

2. How long have you had these concerns? _________ Was it sudden or gradual? __________ Any change in past 90 days? Yes/No

3. If this is due to a work related injury, please explain and give date of injury: ____

4. Have you <u>ever</u> been exposed to loud noise? Yes / No. If yes, please check all that apply. **Hearing protection worn?** Yes / No

   _____Farm Machinery ______Music _____Firearms _____Factory Noise _____Power tools
   _____Military _____Jet engines Other ____

5. Do your ears produce a buildup of cerumen (ear wax)? Yes / No Any drainage from ears in the past 90 days? Yes / No

6. Have you seen a physician about your ears/hearing? Yes / No If yes, when and where? _________________________________

7. Have you ever had a **hearing test**? Yes / No. If yes, when and where? ____

8. Have you ever had **surgery, chemotherapy,** or **radiation therapy** <u>that affected your hearing or balance</u>? Yes / No
   If so, what type and when?
   ____

9. Is there a history of hearing loss in your family? Yes / No. If so whom? ____

10. Please check any of the following that you currently have **or** have had in the past:

____Arthritis ____Cardio-vascular disease ____Measles/Mumps ____Scarlet Fever
____Ear Infections ____Pacemaker ____Meningitis ____Diabetes: Type 1 or Type 2
____Bell's Palsy ____High blood pressure ____Cancer ____Thyroid
____HIV ____High Cholesterol ____Meniere's ____Depression or Mood Disorder
____Malaria ____Stroke/TIA ____Migraines ____Dizziness/Vertigo
____Hepatitis ____Head injury ____Parkinson's ____Other (please specify ____________________)

11. How much do you consume of the following: caffeine ____cups per day; nicotine ____times per day; alcohol _____ drinks per day/week.

12. Do you use recreational drugs? Yes / No. If so, which ones and how often? ____

13. Please circle the best rating for your overall level of stress: **Very Low** **Low** **Normal** **High** **Very High**

14. Do you clench or grind your teeth (TMJ/Bruxism)? ____

Current Medications/Supplements *(use back of page if needed)*

Medication Name	To Treat What Condition?	Dosage	Administered (circle one)
			Oral / Topical / Injection / IV
			Oral / Topical / Injection / IV

Current Medications/Supplements, cont'd.

Medication Name	To Treat What Condition?	Dosage	Administered (circle one)
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