ALBUQUERQUE
HEARING AND BALANCE

Adult Case History

Name: _____ Visit Date: _____

What is the reason for your visit today? _____
_____

What health conditions are you being treated for?

__ Arthritis	__ Head Injury	__ Malaria	__ Parkinson's
__ Asthma	__ Heart Issues	__ Measles	__ Scarlet Fever
__ Bell's Palsy	__ Hepatitis	__ Meningitis	__ Sinusitis
__ Cancer	__ High Blood Pressure	__ Mumps	__ Stroke/TIA
__ Diabetes Type I or II	__ HIV	__ Neurological Issues	__ Visual (Eye) Issues

__ Other(s)_____

What medications are you taking? Please list the health condition each is prescribed to treat.

_____
_____
_____

Are you having trouble hearing?	Yes ___	No ___
If yes: Date of Onset _____		
Does one ear hear better than the other?	Yes ___	No ___
Have you ever worn/currently wear hearing devices/aids?	Yes ___	No ___
Does anyone in your family have hearing difficulties?	Yes ___	No ___
Have you ever been exposed to loud noises?	Yes ___	No ___
If yes, please list: _____		
Do you believe your hearing issues are related to a work incident?	Yes ___	No ___
Are you having trouble with your memory?	Yes ___	No ___
Do you smoke cigarettes?	Yes ___	No ___
Have you ever had a stroke or head injury?	Yes ___	No ___
Do you have TMJ jaw problems?	Yes ___	No ___
Have you ever been seen by an ear specialist (ENT, otolaryngologist)?	Yes ___	No ___
Have you ever had ear surgery (including tubes)?	Yes ___	No ___
Are you having pain in your ears?	Yes ___	No ___
Have you had any drainage from your ears?	Yes ___	No ___
Have you been treated for an ear infection or perforated eardrum?	Yes ___	No ___
Are you experiencing dizziness / lightheadedness / imbalance?	Yes ___	No ___
Have you fallen within the last 3 months?	Yes ___	No ___
Do you have any ringing, buzzing, roaring sounds in your ears or head?	Yes ___	No ___

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Choose the situations in which you are having the greatest difficulty hearing:

___ Soft speech	___ Landline phone	___ Movie theatre
___ Groups of people	___ Cell phone	___ Lectures
___ Noisy environments	___ Television	___ Performance halls
___ Religious services	___ Radio	___ Outdoor / Nature sounds

On a scale from 0 to 10, how severe would you say your hearing difficulties are?

Circle → 0 1 2 3 4 5 6 7 8 9 10

Not severe Somewhat severe Very severe

On a scale from 0 to 10, how motivated are you to do something about your hearing difficulties?

Circle → 0 1 2 3 4 5 6 7 8 9 10

Not motivated Somewhat motivated Very motivated

If you are having difficulties hearing, how have you been managing your hearing problem?

___ I wear hearing devices	__ right / __ left / __ both
___ I have hearing devices but do not wear them	__ right / __ left / __ both
___ I tried hearing devices but did not purchase them	__ right / __ left / __ both
___ I have done listening training	
___ I try to lip read	
___ I have not done anything yet	
___ I don't notice any hearing problems	

If you already have hearing devices, please indicate when and where you were fit:

_____

If considering hearing devices, please rate the following items based on their importance to you:

1 = most important 2 = important 3 = neutral 4 = not important

___ sound clarity	___ easy to use	___ comfortable to wear	___ cost
___ best technology	___ smartphone connection	___ appearance	___ reliability

What goals do you have for today's visit?

_____

_____

Questions for the audiologist:

_____

_____

Leave blank for administrative use