THE HEARING CLINIC

ADULT CASE HISTORY

NAME: _____ DATE: _____

	(Circle One)	
Do you feel you have a hearing problem? • If so, when did you first notice it? _____ • Do you know what caused it? _____	YES	NO
Do you feel one ear hears better than the other? • *Which One?* _____	YES	NO
Is your hearing better on some days than others?	YES	NO
Does anyone in your family have a hearing problem? • *If so, who?* _____ • *Do you know what caused it?* _____	YES	NO
Have you ever had earaches or draining ears?	YES	NO
Do you ever have blood or discharge from your ears?	YES	NO
Do you ever feel dizzy? • Describe severity, duration, and last incident: • _____	YES	NO
Do you have frequent headaches?	YES	NO
Have you ever had surgery in one or both ears? • *If so, when?* _____	YES	NO
Have you ever been treated with chemotherapy? • *If so, describe:* _____	YES	NO
Are you diabetic?	YES	NO
Do you use any type of tobacco products? • If So, When and What Type _____	YES	NO

(Please Turn Over for Additional Questions)

Do you drink Alcohol? • **If so, how often and how much?** _____	**YES**	NO
Do you ever have ringing or buzzing in your ears? • ***If so, describe*:** _____ • ***If so, does it interfere with your lifestyle?*** _____	**YES**	NO
Have you ever been exposed to loud noises (e.g., *factory, farm machinery, carpentry, power tools, construction, firearms, etc.*)?	**YES**	NO
Have you ever seen a physician for your hearing problem?	**YES**	NO
Do you have difficulty hearing in group situations?	**YES**	NO
Have you ever worn a hearing aid?	**YES**	NO
Do you have any objections to wearing a hearing aid?	**YES**	NO
Do you have any difficulty understanding on the telephone? • **Landline or Cell (circle)**	**Yes**	NO
Do you have a cell phone? • **Android or iPhone (circle)**	**YES**	NO
Do you have any physical limitations such as *paralysis, blindness, skin allergies, arthritis, eczema, etc.?* • ***If so, please list*:** _____	**YES**	NO
What would you say are your three (3) most important communication needs? 1. _____ 2. _____ 3. _____	**Please List**	

(Please Turn Over for Additional Questions)

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