

**ADULT CASE HISTORY  
HEARING**

Date: \_\_\_\_\_

Center No. \_\_\_\_\_

**Personal Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
(Last) (First) (Initial)

Address \_\_\_\_\_  
(Street and Number) (City) (State)

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Occupation \_\_\_\_\_

Married? \_\_\_\_\_ No. of children \_\_\_\_\_ Ages: \_\_\_\_\_

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

**Information Concerning Problem**

1. How old were you when the hearing loss was called to your attention? \_\_\_\_\_

2. What has been done about it? \_\_\_\_\_

3. What do you feel caused your hearing problem? \_\_\_\_\_

4. Have your ears ever been examined by a physician? \_\_\_\_\_ List physician and dates:  
\_\_\_\_\_

5. Has either ear ever pained and ached? \_\_\_\_\_ When? \_\_\_\_\_  
Describe: \_\_\_\_\_

6. Have you ever had draining ears? \_\_\_\_\_ Which ear? \_\_\_\_\_ How often? \_\_\_\_\_  
When was the last time? \_\_\_\_\_

7. Has there been any obvious change in your hearing within the last six months? \_\_\_\_\_  
Within the last year? \_\_\_\_\_ Last two years? \_\_\_\_\_

8. Have you any allergies? \_\_\_\_\_ Describe \_\_\_\_\_

9. Do you every feel dizzy? \_\_\_\_\_ How often? \_\_\_\_\_

10. Does your hearing seem better on some days then others? \_\_\_\_\_

11. Which do you feel is your better ear? \_\_\_\_\_ Why? \_\_\_\_\_

12. Do you have trouble following conversations in noisy areas? \_\_\_\_\_

13. Have you ever had a speech or language evaluation? \_\_\_\_\_

14. Do you have trouble maintaining attention? \_\_\_\_\_ Or are you easily distracted? \_\_\_\_\_

15. Do loud sounds bother you? \_\_\_\_\_
16. Do you have trouble hearing at the movies? \_\_\_\_\_ Lectures? \_\_\_\_\_  
 In a group? \_\_\_\_\_ In talking to one person? \_\_\_\_\_ TV? \_\_\_\_\_ Radio? \_\_\_\_\_  
 On the telephone? \_\_\_\_\_
17. Have you ever exposed to loud noises? \_\_\_\_\_ Describe: \_\_\_\_\_  
 \_\_\_\_\_
18. Do you have any ringing in your ears? \_\_\_\_\_  
 a) If so, is it constant or intermittent? \_\_\_\_\_  
 b) If so, is it in one or both ears? \_\_\_\_\_  
 c) If so, please describe the sound \_\_\_\_\_

Hearing Aid Information

1. Have you ever worn a hearing aid? \_\_\_\_\_
2. Do you wear one now? \_\_\_\_\_ Model and make of aid worn \_\_\_\_\_  
 \_\_\_\_\_
3. When did you first start wearing a hearing aid? \_\_\_\_\_
4. Date of purchase of present aid: \_\_\_\_\_
5. By whom was the aid recommended? \_\_\_\_\_
6. Has present aid been: Satisfactory? \_\_\_\_\_ Unsatisfactory? \_\_\_\_\_
7. How many hours a day do you wear your hearing aid? \_\_\_\_\_
8. How often do you wear your hearing aid? \_\_\_\_\_

Occupational Information

1. Has your hearing ever caused you to change jobs? \_\_\_\_\_
2. Do you have any difficulty in your present occupation because of your hearing? Explain: \_\_\_\_\_  
 \_\_\_\_\_
3. Is it noisy where you work? \_\_\_\_\_ Explain: \_\_\_\_\_
4. Do you have any hobbies? \_\_\_\_\_ If so, please list them \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

1. Has anyone in your family ever had a hearing problem? \_\_\_\_\_ How related? \_\_\_\_\_
2. What caused their hearing loss? \_\_\_\_\_
3. Do any of these relatives wear hearing aids? \_\_\_\_\_
4. How long have they been hard of hearing? \_\_\_\_\_

### Medical History

Indicate illnesses you have experienced:

Mumps \_\_\_\_\_

Rickets \_\_\_\_\_

Scarlet Fever \_\_\_\_\_

Noises in the ear \_\_\_\_\_

Influenza \_\_\_\_\_

Earaches \_\_\_\_\_

Polio \_\_\_\_\_

Allergies \_\_\_\_\_

Sinus \_\_\_\_\_

Headaches \_\_\_\_\_

Measles \_\_\_\_\_

Nausea \_\_\_\_\_

Meningitis \_\_\_\_\_

Dizziness \_\_\_\_\_

Chicken Pox \_\_\_\_\_

Drug/Chemotherapy \_\_\_\_\_

Pneumonia \_\_\_\_\_

Cancer \_\_\_\_\_

Tonsillitis \_\_\_\_\_

High Fever \_\_\_\_\_

Convulsions \_\_\_\_\_

Concussion \_\_\_\_\_

Chronic Colds \_\_\_\_\_

Loss of Consciousness \_\_\_\_\_

Surgery:

Tonsillectomy \_\_\_\_\_

Adenoidectomy \_\_\_\_\_

Middle ear surgery \_\_\_\_\_

Other \_\_\_\_\_

COMMENTS: