SHOW LOW
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Jeffrey Moore
Au.D., *Doctor of Audiology*

Victoria Karim
Au.D., *Doctor of Audiology*

Adult Case History

Name:____ Age:______________ Birth Date:____________

Referred By:____________________ Primary Care Physician:_______________________ Today's Date:__________

PRIMARY COMPLAINT:

Do you have hearing problems? ☐ Yes ☐ No If yes, which ear? ☐ Right ☐ Left ☐ Both

Has the hearing loss been: ☐ Gradual? ☐ Sudden? ☐ Fluctuating?

Do you presently use a hearing device? ☐ Yes ☐ No If yes, for how long?__________________________

Are you interested in using a hearing device? ☐ Yes ☐ No

When was your last hearing exam?__________________ By whom?_________________________________

What were the recommendations?____

Do you hear noises in your ears or head? ☐ Yes ☐ No If yes, which ear? ☐ Right ☐ Left ☐ Both

How often do you hear noises? ☐ Constantly ☐ Occasionally ☐ Rarely

Do you ever have a feeling of fullness or stuffiness in your ears? ☐ Yes ☐ No

Have you recently experienced drainage from your ear? ☐ Yes ☐ No

Do you ever experience facial numbness, weakness, or tingling? ☐ Yes ☐ No

Are you experiencing any ear pain? ☐ Yes ☐ No

Are you ever dizzy, unsteady, or off-balance? ☐ Yes ☐ No

If yes, is your dizziness accompanied by: **Nausea?** ☐ Yes ☐ No **Vomiting?** ☐ Yes ☐ No **Noises in your ears?** ☐ Yes ☐ No

Have you ever had any ear surgery? ☐ Yes ☐ No If yes, describe:______________________________________

Have you ever been exposed to loud noises? ☐ Yes ☐ No How Recently?____ Describe:____________________

Does anyone in your family have a hearing problem? ☐ Yes ☐ No

Are you currently taking medication? ☐ Yes ☐ No If yes, describe:___________________________________

Allergies to any medications, plastics, etc.?____

Are you diabetic? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No

What is your occupation?____

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Does a hearing problem do any of the following:

	Always	Sometimes	Never
Make it difficult for you to converse on the telephone?	☐	☐	☐
Cause others to complain that you turn up the television or radio too loud?	☐	☐	☐
Cause you difficulty following conversations in a restaurant?	☐	☐	☐
Limit or hamper your personal or social life?	☐	☐	☐
Cause you to have to ask people to repeat themselves?	☐	☐	☐
Cause you difficulty hearing in the presence of background noise?	☐	☐	☐
Cause you difficulty hearing women's or children's voices?	☐	☐	☐
Cause you to hear people speak but fail to understand what they are saying?	☐	☐	☐
Cause you to feel as though others mumble?	☐	☐	☐
Cause you to feel stressed or tired when listening for long periods of time?	☐	☐	☐

Please provide the top three listening situations where you would like to hear better:

1.____

2.____

3.____

Please select your current lifestyle and, if different, please identify your desired lifestyle.

Active Lifestyle *(Frequent Background Noise)*

☐ Current ☐ Desired

Casual Lifestyle *(Occasional Background Noise)*

☐ Current ☐ Desired

Quiet Lifestyle *(Limited Background Noise)*

☐ Current ☐ Desired

Very Quiet lifestyle *(Rare Background Noise)*

☐ Current ☐ Desired

Notes: