**SHOW LOW**
2600 S. White Mountain Rd.
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Audiology, Inc.
HEARING & BALANCE SERVICES

**SAFFORD**
620 S Central Ave, Ste B
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**Jeffrey R. Moore, Au.D.**
Doctor of Audiology

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

# Adult Case History

Name:_____ Age:____ Birthdate:_____
Referred By:_____
Primary Care Physician:_____ Today's Date:_____

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**PRIMARY COMPLAINT: _____**

Do you have hearing problems? Yes ____ No ____
Which Ear? Right ____ Left ____ Both ____
Has the hearing loss been: Gradual? ____ Sudden? ____ Fluctuating? ____
Do you presently use a hearing device? Yes ____ No ____ 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 ____
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 ____
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 ____ Describe: _____

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

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

Are you currently taking medication? Yes ____ No ____ Describe: _____
Allergies to any medications, plastics, etc.? _____
Are you diabetic? Yes ____ No ____
Do you have a pacemaker? Yes ____ No ____
What is your occupation? _____
Do you Smoke? Yes ____ No ____

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**Does a hearing problem…**

| | 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 to have difficulty hearing in the presence of background noise? | ☐ | ☐ | ☐ |
| Cause you to have 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 other's 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:_____
_____
_____
_____