SHOW LOW
2600 S White Mountain Rd,
Show Low, AZ 85901
Phone: (928) 537-3456
Fax: (928) 537-3469

Audiology, Inc.
HEARING & BALANCE SERVICES

SAFFORD
620 S Central Ave, Ste B
Safford, AZ 85546
Phone: (928) 428-1613
Fax: (928) 428-0055

ADULT CASE HISTORY

Name: _____ Age: _____ Birthdate: _____

Referred By: _____

Primary Care Physician: _____ Today's Date: _____

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 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
- Is your dizziness accompanied by vomiting? ☐ Yes ☐ No
- Is your dizziness accompanied by noises in your ears? ☐ Yes ☐ No

Have you ever had any ear surgery? ☐ Yes ☐ No

- If yes, please describe: _____

SHOW LOW
2600 S White Mountain Rd,
Show Low, AZ 85901
Phone: (928) 537-3456
Fax: (928) 537-3469

Audiology, Inc.
HEARING & BALANCE SERVICES

SAFFORD
620 S Central Ave, Ste B
Safford, AZ 85546
Phone: (928) 428-1613
Fax: (928) 428-0055

Have you ever been exposed to loud noises? ☐ Yes ☐ No

If yes, please describe when and what happened: _____

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

Are you currently taking medication? ☐ Yes ☐ No

If yes, please list: _____

Allergies to any medications, plastics, etc.? ☐ Yes ☐ No

If yes, please list: _____

Are you diabetic? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

What is your occupation? _____

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 you would like to hear better in:

1. _____
2. _____
3. _____

Please select your *current* lifestyle and if different please circle your *desired* lifestyle:

☐ **Active Lifestyle** — Frequent Noise

☐ **Casual Lifestyle** — Occasional Noise

☐ **Quiet Lifestyle** — Limited Noise

☐ **Very Quiet Lifestyle** — Frequent Noise