Center for Hearing & Balance
Bloomsburg University
Centennial Hall 3rd Floor
400 East 2nd Street
Bloomsburg, PA 17815

ADULT AUDIOLOGICAL CASE HISTORY

A. IDENTIFYING INFORMATION: Date: _____

Name: _____
First Middle Last

Address: _____
Street Address City State Zip

Date of Birth: _____ Sex: _____ Marital Status: _____ Occupation: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Email Address: _____

Referral Source: _____ Reason for evaluation: _____

B. MEDICAL HISTORY:

1. Any illness? _____

If yes, please describe: _____

_____

_____

2. Have you had any previous hearing tests? Yes ☐ No ☐

Date of last Evaluation: _____ Location: _____

Results: _____

3. Any history of ear infections? Yes ☐ No ☐ History of ear surgery? Yes ☐ No ☐

If yes, please describe: _____

4. Do you have a feeling of pain or fullness in your ear(s)? Yes ☐ No ☐

If yes, please describe: _____

_____

5. Drainage from ear(s)? Yes ☐ No ☐

If yes, please describe: _____

_____

6. Have you had any dizziness? Yes ☐ No ☐

Which of the following best describes your dizziness?

__ The room seems like it's spinning and I'm still
__ I feel like I am spinning and the room is still
__ I feel sick to my stomach
__ Other (describe)_____
__ I feel like I am going to fall down
__ I feel lightheaded
__ I feel off-balance in space

_____

When did you start feeling dizzy? _____

7. Do you hear any noises in your ear(s)? Yes ☐ No ☐

The noises are in the: Right ear ____ Left ear ____ Both ears ____

The noises are present: Sometimes ____ Often ____ Always ____

When did you start having the noises? _____

Describe the noises: Roaring ____ Ringing ____ Buzzing ____ Pulsing ____ Chirping ____

Hissing ____ Humming ____ Other _____

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

Please indicate the type(s) of noise:

___ Gunfire
___ Power lawn mowers
___ Power tools
___ Military tanks
___ Motorcycles
___ Factory noise
___ Loud music
___ Other types_____
___ Explosions
___ Aircraft
___ Heavy equipment

Are you exposed to noise daily? Yes ☐ No ☐

9. Have you seen an ENT specialist? Yes ☐ No ☐

If yes, please describe reason for evaluation: _____

_____

10. Associated and serious illnesses (include onset, duration, mediation):

___Ear infections	___Respiratory system	___Digestive
___Headaches	___Diabetes	___Neurological Impairment
___Sinus problems	___Thyroid	___Urinary/kidney
___Sleep Disorder	___Depression/Anxiety	___Bone/Joint
___Blood Pressure	___Reproductive System	

Describe:_____

_____

_____

11. Have you had any accidents or head injuries? Yes ☐ No ☐

Describe: _____

_____

12. Do you have a family history of hearing loss? Yes ☐ No ☐

Describe: _____

_____

C. <u>CURRENT HEALTH STATUS:</u>

1. What is your current health status? Do you have any health problems? Yes ☐ No ☐

Describe: _____

_____

2. Are you currently taking any medications? Yes ☐ No ☐

List: _____

_____

_____

D. <u>COMMUNICATION SITUATIONS:</u>

1. Do you have any problems hearing? Yes ☐ No ☐

Which ear? Right ____ Left ____ Both ____

When did you first notice it? _____

Has the hearing loss been: Sudden ____ Gradual ____ Fluctuating ____

2. Three of your most difficult listening situations are:

   a. _____

   b. _____

   c. _____

3. Does your hearing loss interfere with communication? Yes ☐ No ☐

If yes, describe: _____

_____

E. <u>HEARING AIDS:</u>

Check all that apply

____ I do not own a hearing aid; I am interested in obtaining additional information

____ I do not own a hearing aid; I am not interested in getting a hearing aid at this time

____ I own a hearing aid now, but I do not use it for the following reason: _____

_____

___ I owned a hearing aid at one time; I quit using the hearing aid for the following reason:

_____

___ I currently wear hearing aids and they are most helpful: _____

_____

Type:_____ Make/Model: _____ Ear(s): _____

Length of use (years): _____

Purchased from: _____