Adult Case History Form

Patient Name: _____ Date of Completion: _____

Date of Birth: _____ Gender: _____ Primary Language: _____

Marital Status: Single Married Divorced Widowed Domestic Partner

Race: White African-American Asian American Indian Other: _____

Ethnicity: Hispanic or Latino

Current Employment Status: Full-time Part-time Retired Unemployed Stay at Home Parent Student

Current Employer: _____ Position: _____

Highest Level of Education: _____

Do you currently use recreational drugs? Yes No

If yes, what drugs: _____

How often: Daily Weekly Monthly Occasionally Rarely

Do you currently use any tobacco products? Yes No

If yes, what do you use: Cigarettes Cigars Pipe Smokeless Other: _____

If yes, amount of use per day: _____

Do you currently drink alcoholic beverages? Yes No

If yes, how often: Daily Weekly Monthly Occasionally Rarely

Medical History

Current Medications:

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Allergies (foods, medications, plastics, etc.): _____

_____

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence: _____

_____

Have you been immunized? Yes No

If yes, for what illnesses or diseases: _____

Have you experienced any of the following major medical conditions (please check all that apply):

☐**AIDS/HIV**	☐**Genetic Disorders**	☐**Meningitis**
☐**Arthritis**	☐**Headaches**	☐**Mumps**
☐**Blood Disorders**	☐**Head Injury**	☐**Scarlet Fever**
☐**Cancer**	☐**Heart Problems**	☐**Stroke**
☐**Chicken Pox**	☐**High Blood Pressure**	☐**TMJ**
☐**Depression**	☐**High Fevers**	☐**Typhoid**
☐**Diabetes**	☐**Influenza**	☐**Vascular Problems**
☐**Diphtheria**	☐**Malaise**	☐**Other: _____**
☐**Encephalitis**	☐**Malaria**	
☐**Fatigue**	☐**Measles**	

Please check all medical symptoms or conditions that apply:

- **Eye problems (such as blurred or double vision, pain):** Yes No
- **Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues):** Yes No
- **Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations):** Yes No
- **Respiratory issues (such as shortness of breath, cough, wheezing):** Yes No
- **Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain):** Yes No
- **Musculoskeletal issues (such as joint pain, swelling, recent trauma):** Yes No
- **Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness):** Yes No
- **Psychiatric issues (such as depression, anxiety, compulsions):** Yes No
- **Endocrine symptoms (such as frequent urination, hot flashes):** Yes No
- **Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands):** Yes No
- **Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency):** Yes No

Comments related to Review of Symptoms above:

Audiologic History

Do you experience hearing loss? Yes No

If so, which ear? Right Left Both

If you experience hearing loss, which best describes it? Gradual Fluctuating Sudden

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Have you ever had a hearing test? Yes No

If so, when: _____

Which ear do you typically use to talk on the telephone: Right Left

Have you ever worn or tried a hearing aid or amplifier? Right ear Left ear Both ears

What type and/or style of hearing aid or amplifier: _____

Please describe your experience: _____

Please check all of the medical conditions that apply:

☐**Developmental disorder/delay**
If checked, please explain: _____
☐**Dizziness or unsteadiness**
If checked, is it accompanied by (please circle): Vomiting Nausea Ear Noises
☐**Ear deformity**
If checked: Right ear Left ear Both ears
☐**Ear drainage**
If checked: Right ear Left ear Both ears
☐**Ear pain**
If checked: Right ear Left ear Both ears
☐**Family history of hearing loss**
If checked, who is the family member: _____
☐**History of ear infections**
If checked: Right ear Left ear Both ears
☐**History of earwax buildup**
☐**History of noise exposure**
If checked, please describe: _____
☐**Previous ear surgery**
If checked: Right ear Left ear Both ears
If so, when: _____
☐**Tinnitus/ringing/noises in ears**
If checked: Right ear Left ear Both ears
If so, frequency: _____
☐**Other (please describe): _____**

Hearing Handicap Screening (please select the most appropriate response):

- **Does a hearing problem cause you to feel embarrassed when meeting new people?**

  Yes No Sometimes

- **Does a hearing problem cause you to feel frustrated when talking to members of your family?**

  Yes No Sometimes

- **Do you have difficulty hearing when someone speaks in a whisper?**

  Yes No Sometimes

- **Do you feel handicapped by a hearing problem?**

  Yes No Sometimes

- **Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?**

  Yes No Sometimes

- **Does a hearing problem cause you to attend lectures or religious services less often than you would like?**

  Yes No Sometimes

- **Does a hearing problem cause you to have arguments with family members?**

  Yes No Sometimes

- **Does a hearing problem cause you difficulty when listening to TV or radio?**

  Yes No Sometimes

- **Do you feel that any difficulty with your hearing limits or hampers your personal or social life?**

  Yes No Sometimes

- **Does a hearing problem cause you difficulty when in a restaurant with relatives and friends?**

  Yes No Sometimes