UNIVERSITY OF THE
PACIFIC

Adult Audiologic Case History

Date _____

Patient Name _____ D.O.B. _____

GENERAL

What is your primary reason for coming in today? _____

_____

If you suspect a hearing loss, how long have you noticed this problem? _____

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

Was the onset gradual or sudden? _____

Do you have a better hearing ear? ☐ Yes ☐ No

If yes, please describe _____

Does your hearing fluctuate? ☐ Yes ☐ No

If yes, please describe _____

Have you ever been exposed to occupational or recreational noise? (ie. machinery, music, gunfire) ☐ Yes ☐ No

If yes, please describe _____

Does anyone in your family have hearing loss? ☐ Yes ☐ No

If so, who? _____

Have you ever had your hearing tested? ☐ Yes ☐ No

If yes, when? _____

What were the results? _____

Have you seen a physician regarding your hearing concerns? ☐ Yes ☐ No

If yes, when and where? _____

MEDICAL

Do you have a history of ear infections or ear drainage? ☐ Yes ☐ No

If yes, when? _____

Do you have any pain or pressure in your ears? ☐ Yes ☐ No

If yes, please describe _____

Have you ever had medical/surgical treatment for your ears? ☐ Yes ☐ No

If yes, when? _____

Type of procedure _____

Do you have dizziness, balance problems or a history of falls? ☐ Yes ☐ No

If yes, please describe _____

Do you notice any sound in your ears (i.e. ringing, buzzing, humming, etc.)? ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left How frequent? _____

_____

Is it bothersome? ☐ Yes ☐ No

Please describe the sound you hear _____

Please list any medications as well as dosage and frequency (including non-prescriptions) you are currently taking or have taken recently _____

_____

Have you ever had any of the following?

☐ Arthritis
☐ Allergies
☐ Bell's Palsy
☐ Multiple Sclerosis
☐ Head trauma
☐ Dementia/Alzheimer's
☐ Depression/Anxiety
☐ Cancer
(Type/Treatment _____)
☐ Diabetes
☐ Problems with dexterity
☐ Hepatitis
☐ High Blood Pressure
☐ Pacemaker
☐ HIV
☐ High Fevers
☐ Meningitis
☐ Mumps
☐ Measles
☐ Parkinson's
☐ Scarlet Fever
☐ Seizures
☐ Stroke/TIA
☐ Tuberculosis
☐ Vision Problem
☐ Other
Please Describe _____

_____

HEARING HISTORY

Do you have difficulty hearing/understanding in any of the following activities?

☐ Watching TV
☐ Telephone
☐ Other
☐ Meetings
☐ Worship Service
☐ Restaurants
☐ Movies

Please describe _____

Do you have trouble hearing a:

☐ Telephone ring
☐ Doorbell
☐ Alarm clock
☐ Fire/smoke detector
☐ Baby cry
☐ Siren

What environments or situations you would like to hear better in?

1. _____
2. _____
3. _____

HEARING AID HISTORY

Do you use a hearing aid currently? ☐ Right ☐ Left

Make/model/style _____

How long have you had the hearing aid(s)? _____

Average use per day _____

Do you feel you benefit from the hearing aid(s)? ☐ Yes ☐ No

List any problems you are having with the hearing aid _____

_____

What would you improve with your current hearing aid? _____

_____

Additional comments or concerns _____

_____

_____