

Adult Audiologic Case History	Date
atient 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, gunt	fire)
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	5?		
☐ Arthritis	☐ Diabetes	☐ Measles	
☐ Allergies	☐ Problems with dexterity	☐ Parkinson's	
☐ Bell's Palsy	☐ Hepatitis	☐ Scarlet Fever	
☐ Multiple Sclerosis	☐ High Blood Pressure	Seizures	
☐ Head trauma	☐ Pacemaker	□ Stroke/TIA	
☐ Dementia/Alzheimer's	HIV	☐ Tuberculosis	
☐ Depression/Anxiety	☐ High Fevers	☐ Vision Problem	
Cancer	☐ Meningitis	☐ Other	
(Type/Treatment)	☐ Mumps	Please Describe	
HEADING HIGTORY			
HEARING HISTORY Do you have difficulty hearing/underst	anding in any of the following activities?		
		Пр	
☐ Watching TV	☐ Meetings	☐ Restaurants ☐ Movies	
☐ Telephone ☐ Other	☐ Worship Service	□ Movies	
Do you have trouble hearing a:			
Telephone ring	☐ Alarm clock	☐ Baby cry	
☐ Doorbell	☐ Fire/smoke detector	☐ Siren	
What environments or situations you v	vould 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	g 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			
Additional comments or concerns			