Clear Fields

REM Audiology Associates P.C.

ADULT CASE HISTORY

Name: _____ **DOB:** _____

Date: _____ **Referral Source:** _____

Marital Status: _____ **Occupation:** _____

HEARING STATUS

What brought you here today? _____

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

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

Previous hearing tests: ☐Y ☐N Date of Last Evaluation: _____

Results: _____

Best Ear: ☐Right ☐Left ☐Not Sure/Same

Hearing loss onset: ☐Gradual ☐Sudden ☐Fluctuating Ear used on phone: ☐Right ☐Left

Please answer the following questions:

Does your hearing cause you to feel embarrassed when you meet new people?	☐Yes	☐Sometimes	☐No
Does your hearing cause you to feel frustrated when talking to family members?	☐Yes	☐Sometimes	☐No
Do you have difficulty when someone speaks in a whisper?	☐Yes	☐Sometimes	☐No
Does your hearing cause you to attend religious services less often than you would like?	☐Yes	☐Sometimes	☐No
Does your hearing cause arguments with family members?	☐Yes	☐Sometimes	☐No
Does your hearing cause difficulty listening to the TV or radio?	☐Yes	☐Sometimes	☐No
Do you feel your hearing hampers your personal or social life?	☐Yes	☐Sometimes	☐No
Does your hearing cause difficulty when at a restaurant?	☐Yes	☐Sometimes	☐No
Does your hearing cause difficulty talking on the telephone?	☐Yes	☐Sometimes	☐No
Do you feel handicapped by a hearing problem?	☐Yes	☐Sometimes	☐No

List 3 areas where you have the most difficulty hearing or understanding:

1. _____
2. _____
3. _____

HEARING DEVICE HISTORY

Have hearing devices ever been recommended? ☐Yes ☐No

Have you ever worn a hearing device? ☐Yes ☐No

Do you wear one now? ☐Right ☐Left ☐Both ☐None

Do you perceive benefit with your hearing device(s)? ☐Yes ☐No

Medical History

Is there a family history of hearing loss (prior to age 30?) ☐Yes ☐No

If Yes, who? _____

Earaches or drainage within the past 90 days? ☐Yes ☐No

Medical/surgical treatment for your ears? ☐Yes ☐No

Any dizziness (spinning, unsteady, lightheaded)? ☐Yes ☐No

Do you notice any tinnitus (ringing/buzzing/roaring)? ☐Yes ☐No

If Yes, which ear? ☐Right ☐Left ☐Both ☐Can't Tell

Is it bothersome? ☐Yes ☐No How often?

How frequently? ☐Rarely ☐Occasionally ☐Daily ☐Constant

Please describe what you hear: _____

History of ear infections? ☐Yes ☐No

History of pain? ☐Yes ☐No

History of aural fullness (pressure in ears)? ☐Yes ☐No

History of loud noise - recreationally or occupational? ☐Yes ☐No

☐Firearms ☐Factory Work ☐Military Equipment ☐Power Tools

☐Loud Music ☐Explosions ☐Heavy Equipment ☐Farm equipment

☐Motorcycles/recreational vehicles ☐Other: _____

Have you ever had any of the following?

☐Arthritis	☐Depression	☐High Fevers Mumps	☐Multiple Sclerosis
☐Allergies	☐Dementia/Alzheimer's	☐HIV/AIDS	☐Pacemaker
☐Anxiety	☐Headaches/Migraines	☐Hyperthyroidism	☐Parkinson's
☐Bell's Palsy	☐Head Trauma	☐Hypothyroidism	☐Seizures
☐Cancer	☐Hepatitis	☐Kidney/Renal	☐Stroke/TIA
☐Diabetes	☐High Blood Pressure	☐Meningitis	☐Vascular Problems

☐Other: _____

Current Medications (Name, Dose, Freq, Route):

_____

_____

Who did you bring to your appointment with you today?_____