**BEVERLY HOSPITAL AUDIOLOGY DEPARTMENT**

**ADULT CASE HISTORY**

Name _____ Date of Birth _____

**GENERAL INFORMATION**

Have you been to this Audiology Department before?

NO YES How long ago? _____

**HISTORY**

Check the following that may apply:

___ History of ear "problems"
___ History of ear surgery
___ History of dizziness or loss of balance
___ History of occupational or recreational noise exposure (military etc.)
___ History of allergy or sinus problems
___ Family history of hearing loss
___ Family history of dizziness or loss of balance
___ Other medical conditions _____

**MEDICATIONS**

Please list all medications you are currently taking:

_____ _____
_____ _____

Are you taking blood thinners: yes no

**HEARING LOSS**

Do you have a known hearing loss?

NO YES

Is one ear better than the other?

RIGHT LEFT BOTH EARS ARE THE SAME

How long have you noticed the hearing loss?

_____DAYS _____WEEKS _____MONTHS _____YEARS

Has the hearing loss occurred gradually over time or suddenly?

GRADUALLY SUDDENLY

Do you know the cause of your hearing loss?

NO YES _____

Do you have any history of noise exposure such as military service, construction, machinery, dentistry, police, fireman, hunting, musician, etc?

NO YES _____

**RINGING IN THE EAR(S)/TINNITUS**

Do you have ringing in your ear(s)?

NO YES

If yes how long has the ringing been present? _____

In which ear(s) is the ringing present?

BOTH RIGHT LEFT

Is the ringing constant or does it occur in episodes?

CONSTANT EPISODIC

**DIZZINESS/LOSS OF BALANCE**

Do you have a history of dizziness or balance problems?

NO YES

**HEARING AID(S)**

I am currently using a hearing aid(s)

NO YES

I feel my hearing aid(s) help me

NO YES

If no please explain _____

**COMMUNICATION**

Do you have problems in the following situation?

___ Normal conversations
___ Group situations
___ Background noise
___ At work
___ Television
___ Telephone
___ Other _____

How does your hearing loss affect others? (Family & Friends)

_____

Is there someone who is more concerned about your hearing than you are?

_____

Does difficulty with your hearing restrict your social or personal life?

_____

I am interested in a new hearing aid(s)

NO YES

I am interested in a hearing aid(s) repair

NO YES

**OTHER INFORMATION YOU WOULD LIKE TO SHARE**

_____

_____