CASE HISTORY

(ADULT)

NAME_____ SEX: MALE FEMALE
AGE_____ OCCUPATION_____DATE OF BIRTH_____

1. Were you referred here? YES NO
   If yes, by who_____

2. What is the reason for today's visit?_____
   _____

3. Have you ever had your hearing tested before? YES NO

4. Do you believe that you have a hearing loss? YES NO

5. In what situations do you have difficulty hearing? Circle all that apply:
   telephone *radio/tv* *conversation* *in noise*
   male voice *female voice* *other* _____

6. Which hear do you hear better with? RIGHT LEFT BOTH ARE THE SAME

7. Has the hearing loss been: GRADUAL SUDDEN FLUCTUATING

8. Do you think your hearing has changed within the last year? YES NO
   If yes explain_____

9. Do you hear noises in your ears or head? YES NO Which ear : RIGHT LEFT BOTH
   Circle all that apply:
   buzzing *hissing* *ringing* *roaring* *pulsing*
   rushing water *crickets* *thumping* *other*_____

10. Are you having problems with dizziness? YES NO
    If yes, is your dizziness accompanied by: circle all that apply:
    Nausea *Vomiting* *Noises in ear*

11. Have you ever experienced any of the following in the ear? circle all that apply:
    fullness *pain* *itching* *discharge* RIGHT LEFT BOTH

12. Have you ever had ear infections? YES NO
    As a child? _____ Adult?_____ Which ear? RIGHT LEFT BOTH

13. Have you ever had ear surgery? YES NO RIGHT LEFT BOTH

14. Do you currently wear hearing aids? YES NO If yes, for how long?_____

15. Have you been exposed to loud noises? YES NO If yes, circle all that apply:
    firecrackers *headphoned stereo* *guns(military/hunting)* *motorcycles* *industrial noises*
    *other*_____

16. Does anyone in your family have a hearing problem? YES NO
    *If yes, explain*_____

17. Have you ever had a serious head injury? YES NO If yes, did you lose consciousness YES NO
    *explain*_____

additional comments:
_____
_____
_____