West Tennessee Hearing & Speech Center

ADULT CASE HISTORY FORM- HEARING

Name: _____ Age: _____ Sex: _____ D.O.B. _____

Address: _____ City: _____ State: ____ County: _____

Phone: _____ Cell: _____ Employer: _____

Occupation: _____ Insurance: _____

YES NO

☐ ☐ Do you have any problems hearing? If yes, for how long? _____

Which ear? ☐Right ☐Left ☐Both ears

☐ ☐ Do your friends/family complain about your hearing?

☐ ☐ Do you have ringing or other sounds in your ears? If yes, which ear? ☐Right ☐Left ☐Both ears

How often? ☐Constantly ☐Intermittently ☐Unsure

☐ ☐ Have you had dizziness?

☐ ☐ Have you had ear surgery, ear infections, ear pain, skull fracture/concussion?

(Circle all that apply)

☐ ☐ Have you ever been exposed to loud noises on a regular basis? If yes, what kind and for how long?

_____

☐ ☐ Does anyone in your family have a hearing loss? If yes, which family member(s) and how old were they when their loss began? _____

☐ ☐ Have you ever had a hearing test? If yes, please give the year and location of your last test.

_____

☐ ☐ Have you ever worn a hearing aid? If yes, which ear? ☐Right ☐Left ☐Both For how long? ____

☐ ☐ Are you interested in trying hearing aids?

☐ ☐ Do you regularly take medications? If yes, for what condition(s)? _____

_____

Look below and check any conditions that apply:

☐ Meningitis ☐ Cardiac Problems ☐ High Blood Pressure ☐ Diabetes ☐ Scarlet Fever

☐ Other: _____