HearING ASSOCIATES
Hearing is believing

ADULT CASE HISTORY

Patient Name _____ **Date** _____

What is your goal for today's appointment? _____

_____

~ Ear, Hearing & Noise Exposure History ~

(Please circle appropriate answer and provide more information where necessary.)

Known Hearing Loss? Yes No
Right Left Both
How Long? _____
Gradual? Sudden? Fluctuating?

Ear Surgery/Injury? Yes No
Right Left Both
Describe: _____

Ear Pain? Yes No
Right Left Both
Describe: _____

Ear Drainage? Yes No
Right Left Both
Describe: _____

Full/plugged sensation? Yes No
Right Left Both
How Long? _____

Dizziness/Balance problems? Yes No
Does the room spin? Yes No
How long have you had this problem? _____
How frequently does it occur? _____
Duration of an episode? _____

Family History of Hearing Loss? Yes No
Who? _____

Have you ever worked in noise? Yes No
Military? Yes No
Describe: _____

Noisy Hobbies:
Firearm use? Yes No
Loud music/concerts? Yes No
Other: _____

Types of Hearing Protection Used: _____
_____

Tinnitus (ringing/other noises in ears)? Yes No If Yes, ❑ Left ❑ Right ❑ Both

How long has your tinnitus been present? Right _____ Left _____
What does it sound like?
❑ Ringing ❑ Roaring ❑ Rushing
❑ Hissing ❑ Pulsating ❑ Warbling
❑ Musical ❑ Other: _____
Is this a concern?
❑ No ❑ Mild ❑ Moderate ❑ Severe

How often do you hear it?
❑ Rarely ❑ Occasionally ❑ Constantly
Duration:
❑ Brief ❑ Hours ❑ Constant
Loudness:
❑ Soft ❑ Medium ❑ Loud ❑ Very loud

~ Other Medical History ~

(Please circle if you have or have had any of the following)

Allergies
Cancer
Cerebral Palsy
Diabetes
Head Injury
Stroke
Otosclerosis
Vision Problems
Meniere's Disease
HIV/AIDS
Kidney Disease
Meningitis
Multiple Sclerosis
Mumps
Pacemaker
High Blood Pressure
Low Blood Pressure
Implantable Defibrillator

Heart Disease Explain:_____
COVID-19 When:_____ Did you take Paxlovide?:_____

Other Significant Health Issues:

_____
_____
_____
_____

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months? Yes No
If yes, how often?_____ If yes, what type(s)?_____

Please complete reverse side

Patient Name: _____ Date: _____

HEARING LOSS ASSESSMENT

Hearing Handicap Inventory

	Yes	Sometimes	No
1. Does your hearing problem cause you to feel embarrassed when meeting new people?	❑	❑	❑
2. Does your hearing problem cause you to feel frustrated when talking to family?	❑	❑	❑
3. Do you have difficulty hearing when someone speaks in a whisper?	❑	❑	❑
4. Do you feel handicapped by a hearing problem?	❑	❑	❑
5. Does your hearing problem cause you difficulty when visiting friends or family?	❑	❑	❑
6. Does your hearing problem cause you to avoid large group situations?	❑	❑	❑
7. Does your hearing problem cause you to have arguments with friends or family?	❑	❑	❑
8. Does your hearing problem cause you difficulty when listening to TV or radio?	❑	❑	❑
9. Does your hearing problem hamper your personal or social life?	❑	❑	❑
10. Does your hearing problem cause you difficulty when in a noisy situation like a restaurant or party?	❑	❑	❑

Please list four situations where you would like to hear better:

1. _____ 3. _____

2. _____ 4. _____

If you have worn hearing aids before, please answer the following:

HEARING AID HISTORY

How long have you worn hearing aids? _____

Where did you purchase them? _____

How satisfied are you with your hearing aid(s) in the following situations?

At home, one-on-one conversations	❑ Good	❑ OK	❑Poor
In background noise (i.e. restaurants)	❑ Good	❑ OK	❑Poor
On the telephone	❑ Good	❑ OK	❑Poor
On a cellular telephone	❑ Good	❑ OK	❑Poor
In the car/vehicle	❑ Good	❑ OK	❑Poor
At work	❑ Good	❑ OK	❑Poor
Television	❑ Good	❑ OK	❑Poor
In a large room	❑ Good	❑ OK	❑Poor

Are you here to replace your hearing aids if something better is available? Yes Maybe No

Comments: _____

_____