ADVANCED AUDIOLOGY

ADVANCED AUDIOLOGY LOCATIONS

Manhattan Office	☐	**1133 College Ave Ste. C145, Manhattan, KS**
Abilene Office	☐	**511 NE 10th, Second Floor, Abilene, KS**
Beloit Office	☐	**310 W 8th St, Beloit, KS**
Concordia Office	☐	**1100 Highland Dr., Third Floor, Concordia, KS**

Phone 785-320-7388 **Fax 785-320-6056**

AUDIOLOGY ADULT CASE HISTORY

NAME: _____ **DOB**: _____ **TODAY'S DATE:** _____

GENERAL

What is your primary reason for coming in today? _____

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

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

Was the onset gradual or sudden? _____

In which ear do you hear the best? ☐ Right ☐ Left ☐ Same in both ears

Have you ever been exposed to occupational or recreational noise? (Ex: military, music, gun fire)

☐ Yes ☐ No

If yes, please describe: _____

Does anyone in your family have hearing loss? ☐ Yes ☐ No

If so, who? _____

Have you ever had your hearing tested? ☐ Yes ☐ No

If yes, when? _____

What were the results? _____

Have you seen a physician for your hearing? ☐ Yes ☐ No

If yes, when and where? _____

MEDICAL

Have you had earaches or drainage from your ears within the last 90 days? ☐ Yes ☐ No

Have you ever had medical/surgical treatment for your ears? ☐ Yes ☐ No

If yes, at what age? _____

Do you ever have dizziness, balance problems, or falls? ☐ Yes ☐ No

Do you notice any tinnitus (for example: ringing, buzzing, or roaring) in your ears? ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left How frequent: _____

Is it bothersome? ☐ Yes ☐ No

Please describe the sound you hear: _____

(over)

Please list any medications (including non-prescriptions) you are currently taking or have taken recently: _____

_____

Do you have any open sores, bleeding or drainage at this time? ☐ Yes ☐ No

Have you ever had any of the following?

☐ Arthritis
☐ Allergies
☐ Bell's Palsy
☐ Cancer
(Type/Treatment:_____)
☐ Concussion/Skull Fracture
☐ Dementia/Alzheimer's
☐ Depression/Anxiety
☐ Diabetes Type I
☐ Diabetes Type II
☐ Hepatitis
☐ High Blood Pressure
☐ High Fevers
☐ HIV
☐ Kidney Disease
☐ Measles
☐ Meningitis
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Parkinson's
☐ Scarlet Fever
☐ Seizures
☐ Stroke/TIA
☐ Tuberculosis
☐ Vision Problem

Do you currently use tobacco products? ☐ Yes ☐ No

HEARING HISTORY

Which ear do you use on the telephone? ☐ Right ☐ Left

Are you left or right handed? ☐ Right ☐ Left

Is there any other information related to your hearing you feel might be important for the Audiologist to know? _____

HEARING AID HISTORY

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

Do you use a hearing aid now? ☐ Yes ☐ No

If yes, how long have you had a hearing aid? _____

On which ear do you use the hearing aid? ☐ Right ☐ Left

Do you wear it regularly? ☐ Yes ☐ No

Do you feel you benefit from it? ☐ Yes ☐ No

List any problems you are having with the hearing aid: _____

_____

What would you improve with your current hearing aid? _____

_____