Adult Case History Form

Patient name:_____ **Date of completion:**_____

Date of birth:_____ **Gender:**_____**Primary language:**_____

Current Medications:

Drug Name	Dosage (mg)	Frequency (how often)	Route (how do you take it)

Allergies (food, medications, plastics, etc):_____
Other illnesses, surgeries, injuries, hospitalizations since birth and their approximate date of occurrence(s):_____

Have you experienced any of the following major medical conditions (please check all that apply)

- ❑ AIDS/HIV
- ❑ Anxiety
- ❑ Arthritis
- ❑ Blood disorders
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Depression
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Encephalitis
- ❑ Fatigue
- ❑ Genetic Disorder
- ❑ Headaches
- ❑ Head Injury
- ❑ Heart Problems
- ❑ High Blood Pressure
- ❑ High Fevers
- ❑ Influenza
- ❑ Malaise
- ❑ Malaria
- ❑ Measles
- ❑ Meningitis
- ❑ Mumps
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ TMJ
- ❑ Typhoid
- ❑ Vascular Problems
- ❑ Other:_____

<u>Please circle all medical symptoms or conditions that apply:</u>

- Eye problems (blurred or double vision, pain): YES/NO
- Nose, throat or mouth problems (trouble swallowing, nose bleeds, dental issues): YES/NO
- Cardiovascular issues (hypertension, chest pain, swelling, palpitations): YES/NO
- Respiratory issues (such as shortness of breath, cough. wheezing): YES/NO
- Renal issues (such as kidney issues, dialysis): YES/NO
- Gastrointestinal issues (nausea, vomiting, weight changes, diarrhea, pain): YES/NO
- Musculoskeletal issues (joint pain, swelling, recent trauma): YES/NO
- Neurological symptoms (numbness, headaches, tingling, seizures, weakness): YES/NO

Comments related to Review of Symptoms above:_____

Please turn over and complete paperwork

Do you currently use any tobacco products: YES/NO If yes, frequency: _____

Do you currently drink alcoholic beverages: YES/NO If yes, frequency:_____

Please check all conditions that apply:

- ❑ Dizziness or Unsteadiness — If checked, is it accompanied by: vomiting, nausea, ear noises
- ❑ Ear deformity — Right ear Left ear Both ears
- ❑ Ear drainage — Right ear Left ear Both ears
- ❑ Ear pain — Right ear Left ear Both ears
- ❑ Family history of hearing loss — Who?_____
- ❑ History of ear infections — Right ear Left ear Both ears When?_____
- ❑ History of noise exposure — Please describe:_____
- ❑ Previous ear surgery — Right ear Left ear Both ears When?_____
- ❑ Tinnitus Ringing/Noise in ear — Right ear Left ear Both ears How often?_____
- ❑ History of wax buildup — Right ear Left ear Both ears How often?_____

Do you experience hearing loss? Right ear Left ear Both ears

When did you first notice your hearing loss?_____

What do you think caused your hearing loss?_____

Have you ever had a hearing test? Yes/No If so, when?_____

If you experience hearing loss, which best describes it? Gradual Fluctuating Sudden

Have you worn or tried a hearing aid? Right ear Left ear Both ears

Please describe your hearing aid experience:

I have a hearing aid, but I don't use it, or only use it occasionally.
I have tried a hearing aid but returned it.
I have inquired about a device from another office but did not purchase.

What motivated you to come in today?_____

On a scale of 1-10, where do you feel you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? Please circle one

Not motivated 1 2 3 4 5 6 7 8 9 10 Very motivated