GREAT LAKES AUDIOLOGY, LLC

ADULT CASE HISTORY

Name: ________________________________ **DOB:**______________ **Age:**_______ **Date:**_______________

1. Primary Symptoms: ❒ Hearing Loss (❒ Right ear ❒ Left ear) ❒ Tinnitus/Ringing ❒ Dizziness
❒ Difficult Communication (❒ in Quiet ❒ in Noise) ❒ Other ____________

2. How long have you noticed these symptoms? ____

3. Do you feel your hearing is changing? ❒ Yes ❒ No (❒ Gradual ❒ Sudden)

4. What is your current employment status and occupation? ______________________________________

5. Have you ever been exposed to loud noise, either recently or in the past? ❒ Yes ❒ No
If so, please mark all that apply:
❒ Farm Machinery ❒ Music ❒ Hunting/Shooting ❒ Factory Noise
❒ Power Tools ❒ Military ❒ Jet Engines ❒ Other:___________________________

6. Is there a history of hearing loss in your family? ❒ Yes ❒ No If so, who?___________________________

7. Have you ever had an ear infection? ❒ Yes ❒ No (If yes, ❒ as a child ❒ as an adult)

8. Have you ever received medical/surgical treatment for your ears or hearing? ❒ Yes ❒ No
Please describe____

9. Have you, in the past 90 days, experienced dizziness/vertigo or ear pain/drainage?
❒ Yes ❒ No If yes, please describe: ____

10. Do you take any medications/supplements on a regular basis? Please list: (or provide your own list)
Med:_________________ Dose/Freq/Route:__________________________ For:__________________
Med:_________________ Dose/Freq/Route:__________________________ For:__________________
Med:_________________ Dose/Freq/Route:__________________________ For:__________________
Med:_________________ Dose/Freq/Route:__________________________ For:__________________
Med:_________________ Dose/Freq/Route:__________________________ For:__________________
Med:_________________ Dose/Freq/Route:__________________________ For:__________________
(use back for additional room)

11. Please check any of the following that you currently have or have had in the past:
❒ Arthritis ❒ Hepatitis ❒ Meningitis ❒ Parkinson's
❒ Auto-immune dis. ❒ High blood pressure ❒ Migraine ❒ Scarlet Fever
❒ Diabetes Type____ ❒ HIV ❒ Neurofibromatosis ❒ Sinusitis
❒ Head Injury ❒ Measles/Mumps ❒ Neurologic dis. ❒ Stroke/TIA
❒ Heart Trouble ❒ Meniere's disease ❒ Otosclerosis ❒ Vision loss

12. Tobacco use in last 24 months? ______ What product(s) and how often?________________________

13. Other significant medical diagnoses or history?____

14. If you are currently using a hearing aid, or have in the past, please answer the following:
Which ear is/was aided? ❒ Right ❒ Left How long used?________________________
What would improve your current hearing aid? ____

15. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
____ Improved hearing in quiet ____ Improved hearing in noise
____ Cosmetic appearance ____ Expense