# Northwest Ohio Hearing Clinic

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## Adult Case History – Audiology  Today's Date_____

Last Name_____ First Name_____ Middle Initial_____

Date of Birth _____ Age_____ Gender: Male Female

Street Address _____

City_____ State _____ Zip Code _____

Home Phone_____ Other Phone _____

Email Address_____ Family Physician _____

Whom may we thank for referring you?_____

Reason for visit?_____

Where would you like us to send a copy of your results? _____

Who may we discuss your results with? _____

**Please check the appropriate answer:**

Yes No

___ ___ Do you feel hard of hearing? If so, which ear? Right Left Both

For how long?_____ Is the problem becoming worse? Yes No

___ ___ Do you have noises in your ears? If so, which ear? Right Left Both

What does it sound like? Ringing Clicking Buzzing Other_____

_____

___ ___ Have you recently experienced pain or drainage from your ears? Right Left Both

___ ___ Do your ears feel plugged? If so, which ear? Right Left Both

___ ___ Do you have dizzy spells? If so, when was the last spell? _____

Please describe _____

___ ___ Have you ever had an operation on your ears? If so, which ear? Right Left Both

What type of surgery?_____

___ ___ Do you have any difficulties with your sense of touch or handling small objects?

___ ___ Do you have any serious vision problems? If so, what type? _____

_____

Yes No

___ ___ Is there a family history of hearing loss, such as your parents, brothers or sisters?

If so, what type and whom? _____

_____

___ ___ Have you ever worked around loud noises?

___ ___ If so, did you wear ear protection?

How long have you worked around loud noise? _____

What type of noise? (please circle) factory work power tools military construction other?_____

___ ___ Do you have any noisy hobbies?

___ ___ If so, do you wear ear protection?

What type of noise? (please circle) firearms loud engines loud music carpentry other? _____

___ ___ Have you ever worn a hearing aid? Which ear? Right Left Both

What type of hearing aid do you have?_____

How long have you had your hearing aids? _____

___ ___ Have you ever been exposed to any hazardous chemicals?

**Please list any medications you are currently taking**_____

_____

_____

**Which of the following types of medications have you taken? (Indicate dosage and length of time taking)**

___ Diuretics – _____ ___ Anti-inflammatory - _____

___ Chemotherapy – _____ ___ Antibiotics - _____

___ Radiation - _____

**Please check any of the following health problems you have experienced (check all that apply)**

___ Head Trauma/Traumatic Brain Injury
___ Frequent Ear Infections
___ Developmental Disability
___ Stroke
___ Cerebral Palsy
___ Frequent Sever Headaches or Migraine
___ Diabetes
___ Meningitis
___ Scarlet Fever or Prolonged Low Fever
___ Cleft Palate
___ Temporomandibular Joint Disease (TMJ)
___ Other disease of the ear?_____

___ Cytomegalovirus (CMV)
___ Syphilis
___ Hepatitis (A,B, or C)
___ Heart Disease or High Blood Pressure
___ Kidney Disease
___ Arthritis
___ Parkinson's Disease (Tremors)
___ Alzheimer's Disease or Dementia
___ Seizure Disorder
___ Immune Deficiency Disorder
___ Other Neurological Disease_____
___ Cancer – Type? _____