

# VALLEY Hearing Consultants

## Adult Case History Form

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Chief complaint:  Hearing Loss (  Right ear/ Left ear)  Tinnitus/Ringing  Dizziness  
 Difficulty hearing ( in Quiet  in Noise)  Telephone ( Right ear  Left ear)
2. How long have you noticed this difficulty? \_\_\_\_\_
3. Is this problem due to a work-related injury/exposure?  Yes  No  
If so: Date of Injury: \_\_\_\_\_ Explain: \_\_\_\_\_
4. Do you feel your hearing is changing?  Yes  No ( Gradual  Sudden, within the past 90 days)
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. Have you seen an Ear, Nose and Throat physician about this problem?  Yes  No  
If so, who did you see? \_\_\_\_\_ When? \_\_\_\_\_
7. Do you have a history of ear problems?  Yes  No  
  
Please check all that apply:

<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Ear aches	<input type="checkbox"/> Ear canal discharge/ bleeding
<input type="checkbox"/> Excessive ear wax	<input type="checkbox"/> Tubes in the ear	<input type="checkbox"/> Hole/ perforated eardrum
<input type="checkbox"/> Fluids behind the eardrum	<input type="checkbox"/> Soreness/ pain in the ear	<input type="checkbox"/> Permanent hearing loss
<input type="checkbox"/> Fluctuating hearing loss	<input type="checkbox"/> Dizziness or Vertigo	<input type="checkbox"/> Tinnitus (noises in the ears/head)
<input type="checkbox"/> Acoustic Neuromas/ tumors	<input type="checkbox"/> Cholesteatoma	<input type="checkbox"/> Meniere's disease
<input type="checkbox"/> Otosclerosis	<input type="checkbox"/> Collapsing ear canals	<input type="checkbox"/> Ossicular dislocation/ fixation
<input type="checkbox"/> Labyrinthitis	<input type="checkbox"/> Fever over 104 degrees	
8. Have you ever had surgery that may have affected your hearing?  Yes  No
9. Is there a history of hearing loss in your family?  Yes  No If so, who? \_\_\_\_\_
10. Have you ever had an ear infection?  Yes  No (If yes,  as a child  as an adult)
11. Do you hear noises in your ears?  
 Yes  No If yes, please describe: \_\_\_\_\_  
Does it sound like...  Ringing  Buzzing  Hissing  Fluttering  
 Other: \_\_\_\_\_  
How often do you hear it?  All the time  Occasionally  It comes and goes  
How long have you been aware of this problem? \_\_\_\_\_  
How much does it bother you?  Not much  Somewhat annoying  Can't tolerate at all

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**Today's Date:** \_\_\_\_\_

**12.** Have you, in the past 10 years, experienced continuous, recurring or sudden dizziness, Light-headedness, or vertigo?  Yes  No

If yes, please describe: \_\_\_\_\_  
Does it feel like...  The room is spinning  Like you're falling  In a fog  drunken  
How often do you feel that way? \_\_\_\_\_  
When was the first time you felt that way? \_\_\_\_\_  
Do you feel that way now? \_\_\_\_\_ How long do the feelings last? \_\_\_\_\_  
When you begin to feel dizzy, do your ears ring? \_\_\_\_\_  
Have you ever had a CT Scan or MRI for this problem? \_\_\_\_ If yes, when? \_\_\_\_\_  
Results: \_\_\_\_\_

**13.** Do you take any prescription medications on a regular basis? Please list: (or attach a list)

Medication: \_\_\_\_\_ For: \_\_\_\_\_  
Medication: \_\_\_\_\_ For: \_\_\_\_\_  
Medication: \_\_\_\_\_ For: \_\_\_\_\_  
Medication: \_\_\_\_\_ For: \_\_\_\_\_

**14.** Have you ever required chemotherapy?  Yes  No

If yes, what medication was used? \_\_\_\_\_

**15.** Please check any of the following that you currently have or have had in the past:

- |                                       |  |                                       |  |
|---------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Measles      | <input type="checkbox"/> Parkinson's               |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Meningitis   | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mumps        | <input type="checkbox"/> Sinusitis                 |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Neurological | <input type="checkbox"/> Stroke/TIA                |
| <input type="checkbox"/> Head Injury  | <input type="checkbox"/> Malaria             | Symptoms                              | <input type="checkbox"/> Visual Trouble-Loss/Sight |

**16.** If you are currently using a hearing aid, or have in the past, please answer the following:

How long have you used a hearing aid? \_\_\_\_\_  
Which ear is/was aided?  Right  Left  
Where did you get them? \_\_\_\_\_  
How old are these hearing aids now? \_\_\_\_\_  
What would improve your current hearing aid? \_\_\_\_\_

**17.** 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
____ Style/ appearance	____ Cost

**18.** On a scale of 1-10, how motivated are you regarding doing something about your hearing loss?

1	2	3	4	5	6	7	8	9	10
not		somewhat		motivated		very		extremely	
motivated		motivated				motivated		motivated	