

EAR LABS 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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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	