INDIANA UNIVERSITY

Audiology Clinic, 2631 East Discovery Parkway2631 East Discovery Parkway, Bloomington, IN 47408

Adult Case History

Name:_____ Age:_____ Birthdate:____-____-____

Referral Source:_____ Primary Care Physician:_____
Veteran of the US Armed Forces: ☐ Yes ☐ No When:_____

1. Why are you here?:_____

2. Hearing Loss: ☐ Yes ☐ No ☐ Unsure

Which Ear: ☐ Right ☐ Left

Better Ear: ☐ Right ☐ Left Age of Onset:_____

Check if Applicable: ☐ Progressive (☐ gradual / ☐ rapid) ☐ Fluctuant ☐ Sudden Onset

☐ Family History of hearing loss prior to age 50

Who: _____ Relationship to You : _____

Primary Communication partners: _____
Situations that cause difficulty: (check all that apply) ☐ 1 on 1 ☐ in groups ☐ with background noise
☐ at work or volunteer jobs ☐ at home ☐ at social events ☐ using the phone ☐ watching television
☐ in the car Remarks:_____

Do you use Sign Language? ☐Yes ☐ No ☐ Sometimes
Is English your first language? ☐Yes ☐No If not, what is your first language?_____
Will you need an interpreter? ☐ Yes ☐ No

3. Medical History: (check all that apply)

☐ Head injury with unconsciousness (when:_____)
☐ Ear pain (☐ Right ☐ Left ☐ Both) Onset/Describe:_____
☐ Discharge from the ear (☐ Right ☐ Left ☐ Both) Onset/Describe:_____
☐ Fullness or pressure (☐ Right ☐ Left ☐ Both) Onset/Describe: _____
☐ Ear deformity (☐ Right ☐ Left ☐ Both) Onset/Describe: _____
☐ Visible congenital or traumatic deformity of the ear (☐ Right ☐ Left ☐ Both) Onset/Describe: _____
_____
☐ Ear wax accumulation (☐ Right ☐ Left ☐ Both) Onset/Describe: _____
☐ Foreign Body in ear (☐ Right / ☐ Left☐ Both) Onset/Describe: _____

History of Ear Infections: ☐ Yes ☐ No

Ear: ☐ Right ☐ Left ☐ Both Age of Onset:_____ Age of last infection:_____
Treatment: _____
Remarks/Describe:_____

Ear Surgery: ☐ Yes ☐ No

Ear: ☐ Right ☐ Left ☐ Both Type/Date of Surgery: _____
Remarks/Describe:_____

Tinnitus: ☐ Yes ☐ No

Ear: ☐ Right ☐ Left ☐ Both ☐ Constant ☐ Fluctuates

Describe: ☐ Hissing ☐ Ringing ☐ Buzzing ☐ Thumping ☐ Clicking ☐ Other:_____

Irritation level: ☐ Mild ☐ Moderate ☐ Moderate-Severe ☐ Severe ☐ Non-Irritating

Tinnitus treatment: ☐ Yes ☐ No Date/Describe: _____
Remarks:_____

Vestibular/Balance History: ☐ Yes ☐ No

Vertigo: ☐ Yes ☐ No

Other vestibular symptoms: ☐ Light-Headedness ☐ Spinning sensation ☐ Unsteadiness ☐ Imbalance

Accompanying Symptoms: ☐ Nausea ☐ Change in or onset of tinnitus ☐ fluctuating hearing loss
☐ Fullness or Pressure ☐ Other:_____

Two or more falls in the past year or once with an injury: ☐ Yes ☐ No

Do you take Vitamin D? ☐ Yes ☐ No
Vestibular/Balance Treatment(s):_____
Remarks/Describe:_____

Hospitalizations/Surgeries (Date/Type): _____
_____

Medical Conditions:

☐ Diabetes ☐ Cancer ☐ Depression ☐ Multiple Sclerosis ☐ Heart Disease ☐ Vascular Conditions

☐ Meningitis ☐ Autoimmune Disease☐ Head injury ☐ Psychiatric ☐ HIV/AIDS ☐ Migraines

☐ Neurologic conditions ☐ Visual Issues ☐ Other _____

Tobacco use in the last two years: ☐ Yes ☐ No

Type of tobacco product: ☐ cigarettes/cigars/pipes ☐ electronic-cigarette ☐ chewing tobacco

Alcohol Use: ☐ Yes ☐ No Frequency: _____

Recreational drug or marijuana use: ☐ Yes ☐ No Frequency: _____

Current Medications and supplements (include dosage, frequency and route):

Name	Dosage	Frequency	Route

Allergies: _____

4. Noise Exposure: ☐ Yes ☐ No (If yes, please indicate all noise sources below

☐ Factory or Industrial noise ☐ Farm Equipment ☐ Guns, Military Weapons ☐ Power tools / Mowers

☐ Very loud concerts ☐ Personal Music device ☐ Loud Musical Instruments ☐ Aircrafts

☐ Motorcycles / ATV's Other noise (Describe): _____

Have you used ear protection: ☐ Yes ☐ No (Describe): _____

5. Previous Hearing Evaluation: ☐ Yes ☐ No

Where: _____ When:_____

If you have had a previous Hearing Evaluation please include a copy of those results.

6. Hearing Aids: ☐ Currently Worn ☐ Worn in the past ☐ recommended, but not worn ☐ never worn

Ear fit: ☐ Right □ Left □ Binaural *If not worn, why not? _____

_____

Where purchased: _____ When: _____

Consistency of use: _____

Perceived Benefit: _____

Interested in pursuing new hearing aids? □ Yes □ No

Remarks: _____

8. Educational-Vocational History

Are you currently enrolled in any educational program? ☐Yes ☐No

If yes, then what type of program? _____

Are you currently employed? ☐Yes ☐No Occupation (previous or current)?_____

Describe any hearing related work problems:_____

_____

Are you planning on returning to some type of work? ☐Yes ☐No

Will you need special training or help? ☐Yes ☐No

The purpose of the survey below is to identify the problems your hearing loss may be causing you. Answer each question, by checking "Yes", "Sometimes" or "No". Do not skip a question if you avoid a situation because of a hearing loss. IF you use a hearing aid, please answer the way that you hear **WITHOUT** the hearing aid.

S-1. Does a hearing problem cause you to use the phone less often than you would like?	□Yes □Sometimes □No
E-2. Does a hearing problem cause you to feel embarrassed when meeting new people?	□Yes □Sometimes □No
S-3. Does a hearing problem cause you to avoid groups of people?	□Yes □Sometimes □No
E-4. Does a hearing problem make you irritable?	□Yes □Sometimes □No
E-5. Does a hearing problem cause you to feel frustrated when talking to members of your family?	□Yes □Sometimes □No
S-6. Does a hearing problem cause you difficulty when attending a party?	□Yes □Sometimes □No
E-7. Does a hearing problem cause you to feel "stupid" or "dumb"	□Yes □Sometimes □No
S-8. Do you have difficulty hearing when someone speaks in a whisper?	□Yes □Sometimes □No

E-9. Do you feel handicapped by a hearing problem?	□Yes □Sometimes □No
S-10. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	□Yes □Sometimes □No
S-11. Does a hearing problem cause you to attend religious services less often than you would like?	□Yes □Sometimes □No
E-12. Does a hearing problem cause you to be nervous?	□Yes □Sometimes □No
S-13. Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?	□Yes □Sometimes □No
E-14. Does a hearing problem cause you to have arguments with family members?	□Yes □Sometimes □No

S-15. Does a hearing problem cause you difficulty when listening to TV or radio?	□Yes □Sometimes □No
S-16. Does a hearing problem cause you to go shopping less often than you would like?	□Yes □Sometimes □No
E-17. Does any problem or difficulty with your hearing upset you at all?	□Yes □Sometimes □No
E-18. Does a hearing problem cause you to want to be by yourself?	□Yes □Sometimes □No
S-19. Does a hearing problem cause you to talk to family members less often than you would like?	□Yes □Sometimes □No

E-20. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	□Yes □Sometimes □No
S-21. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	□Yes □Sometimes □No
E-22. Does a hearing problem cause you to feel depressed?	□Yes □Sometimes □No
S-23. Does a hearing problem cause you to listen to TV or radio less often than you would like?	□Yes □Sometimes □No
E-24. Does a hearing problem cause you to feel uncomfortable when talking to friends?	□Yes □Sometimes □No
E-25. Does a hearing problem cause you to feel left out when you are with a group of people?	□Yes □Sometimes □No

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Client/Guardian Signature:_____**Date:**_____
Please bring completed forms with you to your appointment. Thank you.

Form date: 01/13/2018