CARLS CENTER FOR CLINICAL CARE AND EDUCATION
CENTRAL MICHIGAN UNIVERSITY

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Audiology Clinic

## ADULT CASE HISTORY-AUDIOLOGY

**Patient's Name**:_____ **Today's Date**:_____
(Last Name) (First Name) (Middle Name)

**Legal Gender** _____ **Title** (please select): Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐

**Gender Identity** _____ Miss ☐ Rev. ☐ Fr. ☐ Sr. ☐ Lord ☐

**Birth Date** (mm/dd/yyyy)_____

**Family physician**: _____ **Referring physician**: _____

**May we send reminders for future appointments?** (please select one) **YES** ☐ **NO** ☐

**Please check the appropriate answer. Complete blank when appropriate.**

**YES NO**

___ ___ Do you feel you have a hearing loss? If so, which ear? Right ☐ Left ☐ Both ☐

For how long? _____ Has it changed? Yes ☐ No ☐

___ ___ Do you have trouble understanding people when they talk?

___ ___ Have you recently experienced pain or drainage in your ears?

___ ___ Do you have noises in your ears? Which ear? Right ☐ Left ☐ Both ☐

What does it sound like? _____
Is it bothersome? Yes ☐ No ☐
How long has it been present? _____

___ ___ Do your ears feel plugged or have pressure? If so, which ear? Right ☐ Left ☐ Both ☐

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

Have you fallen? Yes ☐ No ☐
Please describe: _____

___ ___ Do you have problems with balance? Has it changed? Yes ☐ No ☐

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

What type of surgery? _____

___ ___ Have you ever had a doctor remove wax from your ears?

If so, how long ago? _____ Which ear? Right ☐ Left ☐ Both ☐

Patient Name:_____ Date of Birth: _____

**YES NO**

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

____ ____ If so, what type and whom?_____

_____

____ ____ Have you ever worked around loud noises? Yes☐ No☐
If so, did you wear ear protection? Yes☐ No☐
How long have you worked around loud noise?_____
What type of loud noise? ☐factory work ☐construction ☐farm machinery
(please circle all that apply) ☐motorcycles ☐loud engines ☐power tools
☐loud music ☐lawn mowers ☐gunfire
☐other:_____

____ ____ Do you have any noisy hobbies? If so, do you wear ear protection? Yes☐ No☐
What type of loud noise? ☐ snowmobiles ☐motorcycles ☐ dirt bikes
☐carpentry ☐ power tools ☐ loud engines
☐loud music ☐ gunfire ☐ other:_____

**If you circled gunfire**, please answer:
Do you shoot right-handed or left-handed? _____
What type of guns have you used? _____

____ ____ Have you ever worn a hearing aid? For which ear? Right☐ Left☐ Both☐
If so, when did you obtain it/them?_____
What concerns do you have about your hearing aids?_____

_____

____ ____ Do you use tobacco products? What type? _____

Please indicate whether you have had any of the following health problems: (please check all that apply)

____Allergies
____Sinusitis
_ _Meningitis
_ _Scarlet Fever or Prolonged Low Fever
_ _Prolonged High Fever
_ _Mumps
____Measles
____Tuberculosis (TB)
_ _Cytomegalovirus (CMV)
_ _Syphilis
_ _Hepatitis (A, B or C)
_ _Diabetes (I or II)
____Heart Disease
____High Blood Pressure
_ _Hypothyroidism
_ _Kidney Disease
_ _Frequent Ear Infections
_ _High Cholesterol
____Other Disease of the Ear: _____

____Arthritis
____Tremors (Ex: Parkinson's disease)
_ _Multiple Sclerosis
____Cerebral Palsy
_ _Traumatic Brain Injury/Head Trauma
_ _Concussion or Loss of Consciousness
_ _Alzheimer's Disease or Dementia
_ _Stroke, Brain Attack, TIA or CVA
____Seizure Disorder
____Other Neurological Disease:_____
_ _Frequent Severe Headaches or Migraine
____Developmental Disability
_ _Temporomandibular Joint Disorder (TMJ)
_ _Cleft Palate
_ _Immune Deficiency Disorder
_ _Cancer What type?_____
Treatment:_____