Adult Case History Form

'atient Name		Agt	L	Jaile				
1. Chief complaints:	Difficulty Hearing or Unders	standing (Right/Left/E	Both)Full	ness/Pressure in Ears				
Difficulty Hearing on TelephoneDizziness/VertigoTinnitus (Ringing or Buzzing) (Right/Left/Both)								
2. How long have you noticed this difficulty? Is it sudden or gradual?								
3. Is this problem due to	a work-related injury/exposure?	Yes / No. If yes, plea	se explain and give	date of injury:				
4. Have you <u>ever</u> been ex	sposed to loud noise? Yes / No. Is	f yes, please check all	that apply. Hearin	g protection worn? Yes / No				
Farm Machinery Military		Firearms ther		Power tools				
5. Do your ears produce a	a buildup of cerumen (wax)?	Yes No						
6. Have you seen a physic	cian about your ears/hearing? Yes	/ No If yes, when ar	nd where?					
7. Have you ever had a he	earing test before? Yes / No. If yo	es, when and where?						
7. Have you ever had a har. 1. Have you ever had sur. 1. If so, what type and w. 2. Is there a history of hear.	earing test before? Yes / No. If your gery, chemotherapy, or radiation then? aring loss in your family? Yes / No.	es, when and where? n therapy that affecte o. If so whom?	d your hearing or ba	alance? Yes / No				
7. Have you ever had a harmal for so, what type and when the surface of the so. Is there a history of head of the so. Please indicate if you	earing test before? Yes / No. If your gery, chemotherapy, or radiation hen? aring loss in your family? Yes / No. If your family? Yes / No. If your family?	es, when and where? In therapy that affecte To. If so whom? of the following:	d your hearing or ba	alance? Yes / No				
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Medication List on Other Side – Please Complete

Patient Name	 Age	·	Date	;

Medications

Medication Name	Dosage	Administered (circle one)
		Oral / Topical / Injection / IV
		Oral / Topical / Injection / IV
		Oral / Topical / Injection / IV
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