Adult Case History Form

Patient Name ____ **Age** ________________ **Date** ____________________

1. Chief complaints: ______ Difficulty Hearing or Understanding (Right/Left/Both) ______Fullness/Pressure in Ears

_____ Difficulty Hearing on Telephone _____Dizziness/Vertigo _____Tinnitus (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, please explain and give date of injury: _____________

____

4. Have you ever been exposed to loud noise? Yes / No. If yes, please check all that apply. **Hearing protection worn?** Yes / No

_____Farm Machinery ______Music _____Firearms _____Factory Noise _____Power tools
_____Military _____Jet engines Other ____

5. Do your ears produce a buildup of cerumen (wax)? Yes ________ No_________

6. Have you seen a physician about your ears/hearing? Yes / No If yes, when and where? ________________________________

7. Have you ever had a **hearing test** before? Yes / No. If yes, when and where? ____

8. Have you ever had **surgery, chemotherapy,** or **radiation therapy** that affected your hearing or balance? Yes / No
If so, what type and when?
____

9. Is there a history of hearing loss in your family? Yes / No. If so whom? ____

10. Please indicate if you currently take medications for any of the following:

_____ Diabetes
_____ Pain
_____ Neurologic disease
_____ Thyroid
_____ Blood pressure
_____ Inflammation
_____ Antibiotics
_____ Cancer
_____ Diuretics (fluid pills)
_____ Anxiety
_____ Blood thinners
_____ Vertigo
_____ Depression
_____Cholesterol

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

____Arthritis
____Ear Infections
____Bell's Palsy
____HIV
____Malaria
____Hepatitis
____Cardio-vascular disease
____Pacemaker
____High blood pressure
____High Cholesterol
____Stroke/TIA
____Head injury
____Measles/Mumps
____Meningitis
____Cancer
____Meniere's
____Migraines
____Parkinson's
____Scarlet Fever
____Diabetes: Type 1 or Type 2
____Thyroid
____Other (please specify ____________________)

12. How much do you consume of the following: caffeine ____cups per day; nicotine ____times per day; alcohol _____ drinks per day/week.

Medication List on Other Side – Please Complete

Patient Name ____ **Age** _________________ **Date** ____________________

Medications

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