Adolescent Case History

Patient Information

Name: _____ Responsible Party: _____

Birthdate: _____ Gender: Male Female Other Preferred Phone: Home Mobile Work

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

E-mail Address: _____ Work Phone: _____

Marital Status: _____ Employment Status: _____ Student Status: _____

Primary Language: _____ Ethnicity: Hispanic/Latino Not Hispanic/Latino Race: _____

Guardian/Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Reason for Visit

Chief Complaint: Difficulty Hearing – Right Left Both Tinnitus/Ringing – Right Left Both

Dizziness/Vertigo Auditory Processing

How long have you noticed this difficulty? _____

Hearing History

Have the patient ever had a hearing test? No Yes – When and Where: _____

Do you feel the patient's hearing is changing? No Yes – Gradually Suddenly Fluctuating

What do you think is the cause of the patient's hearing loss? _____

_____

Which ear does the patient use to talk on the phone? Right Left Both

Auditory Problems Checklist: (Check all that apply to the patient)

___ 1. Has a history of hearing loss

___ 2. Has a history of ear infections

___ 3. Does not pay attention (listen) to instruction 50% or more of the time

___ 4. Does not listen carefully to directions-often necessary to repeat instructions

___ 5. Says "huh" and "what" at least five or more times per day

___ 6. Cannot attend to auditory stimuli for more than a few seconds

___ 7. Has a short attention span (If this item is checked, check appropriate time frame)

__ 0-2 minutes __ 2-5 minutes __ 5-15 minutes __ 15-30 minutes

___ 8. Daydreams, attention drifts, not with it at times.

___ 9. Is easily distracted by background sound(s).

___ 10. Has difficulty with phonics

___ 11. Experiences problems with sound discrimination

___ 12. Forgets what is said in a few minutes

___ 13. Does not remember simple routine things from day to day

___ 14. Displays problems recalling what was heard last week, month, year

___ 15. Has difficulty recalling a sequence that has been heard

___ 16. Experiences difficulty following auditory directions

___ 17. Frequently misunderstands what is said

___ 18. Does not comprehend many words – verbal concepts for age/grade level

___ 19. Learns poorly through the auditory channel

___ 20. Has a language problem (morphology, syntax, vocabulary, phonology)

___ 21. Has an articulation (speech) problem

___ 22. Cannot always relate what is heard to what is seen

___ 23. Lacks motivation to learn

___ 24. Displays slow or delayed response to verbal stimuli

___ 25. Demonstrates below average performance in one or more academic areas

Does the patient currently wear hearing aids? No Yes - Right Left Both

Please circle any types of loud noise the patient has been exposed to, either recently or in the past:

Farm Machinery Hunting/Shooting Loud Headphones Music

Other: _____

Is there a history of hearing loss in your family? No Yes – Who? _____ Cause? _____

Has the patient seen an Ear, Nose and Throat Physician? No Yes

If yes, who did they see?_____ When? _____

Any history of, or active drainage from, the ear within the past 90 days? No Yes

If yes, please describe: _____

Has the patient experienced any recent pain or discomfort in the ear? No Yes

If yes, please describe: _____

Has the patient, in the past 90 days, experienced chronic or acute dizziness, lightheadedness, or vertigo? No Yes

If yes, please describe: _____

Medical History

Please circle any of the following that you currently have or have had in the past:

AIDS	Blood disorders	Diphtheria	Heart Problems	Influenza
Anemia	Cancer	Encephalitis	Hepatitis	Kidney Disease-Stage __
Anxiety	Chicken Pox	Fatigue	High Blood Pressure	Loneliness
Appetite Change	Depression	Genetic Disorders	High Cholesterol	Lung Disease
Asthma	Diabetes-Insulin Y/N	Headaches	High Fevers	Malaise
Bell's Palsy	Diabetes-Type 1 or 2	Head Injury	HIV	Malaria

Measles	Obesity	Thyroid Disease	Typhoid
Meningitis	Scarlet Fever	TIA	Vascular Problems
Mumps	Sinusitis	Tonsillitis	Worry
Neurological Symptoms	Stroke	Tooth Decay	Other: _____

Please check all medical symptoms that apply:

_____ Eye problems (such as blurred vision, pain) _____

_____ Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain) _____

_____ Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations) _____

_____ Respiratory Symptoms (such as shortness of breath, cough, wheezing) _____

_____ Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain) _____

_____ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma) _____

_____ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness) _____

_____ Psychiatric Issues (such as depression, anxiety, compulsions) _____

_____ Endocrine Symptoms (such as frequent urination, hot flashes) _____

_____ Hematologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands) _____

_____ Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency) _____

Any history of significant illnesses, surgeries, injuries or hospitalizations: _____

_____

Do you take any prescription or over-the-counter medications? No Yes

If yes, please provide a list at check-in.

Please list any allergies:

___ Food _____

___ Medications _____

___ Plastic _____

___ Metals _____

___ Other _____

Please list all the ways you heard about us: _____

By signing below, I consent for my child to receive audiological services at All Generations Audiology, PLLC. The consent encompasses audiological procedures including, but not limited to, diagnostic testing and rehabilitative treatment.

I understand that this consent form will be valid and remain in effect as long as my child receives audiological care at All Generations Audiology, PLLC.

Signature: _____ Date: _____

Relationship if not signed by patient (i.e. guardian, POA, etc.) _____