Adult Case History

Patient Information

Name: _____ Responsible Party: _____

Title: _____ (Mr., Mrs., Miss., Ms., Dr., etc.)

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: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Reason for Visit

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

Other Sumptoms: Difficulty Hearing – Right Left Both Tinnitus/Ringing – Right Left Both Dizziness/Vertigo

How long have you noticed this difficulty? _____

Hearing History

Have you ever had your hearing evaluated before? No Yes If yes, when: _____

Have you seen an Ear, Nose and Throat Physician? No Yes

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

Do you feel your hearing is changing?

___ Gradually ___ Sudden (within past 90 days)

___ Fluctuating ___ Sudden (longstanding)

How long have you noticed this difficulty? _____

What do you think is the cause of your hearing loss? _____

Which ear do you use to talk on the phone? Right Left Both

Do you use a cell phone or other mobile device? No Yes If yes, please list type (IOS, Android, etc.), Make, and generation of the device): _____

In what situations do you have difficulty hearing? Check all that apply:

_____ It frequently seems that people are mumbling

_____ I sometimes hear words but don't understand

_____ I find it difficult to hear when using the telephone

_____ I have missed the ringing of a telephone

_____ It is difficult to understand when my back is turned

_____ I often need people to repeat what they've said

_____ I find it difficult to hear in noisy places

_____ Others complain that I set the TV too loud

_____ I have been told that I speak loudly

_____ I avoid social events because of my hearing

_____ Other (please specify): _____

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

Factory Noise Farm Machinery Hunting/Shooting Jet Engines Military Music Power Tools

Other (please specify): _____

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

Have you ever had an ear infection? No Yes – In childhood Yes – As an adult

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

If yes, please describe: _____

Have you experienced any recent pain or discomfort in the ear? No Yes

If yes, please describe: _____

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

If yes, please describe: _____

Have you fallen within the past 12 months? No Yes

If yes - how many falls and were you injured in one of the falls.

Please describe: _____

Hearing Aid History

Do you currently wear hearing aids? No Yes - Right Left Both

Check all that apply for you while you are wearing your hearing aid(s):

_____ Some sounds are too loud

_____ Sounds are too soft

_____ Pain

_____ Sounds are tiny or metallic

_____ Difficulty cleaning the hearing aid

_____ Naturalness of sound

_____ Trouble understanding in quiet

_____ Wind noise

_____ Trouble using the telephone

_____ Feedback or whistling

_____ Changing the battery

_____ Repair issues

_____ Trouble understanding in noise

_____ Do not like the appearance of the instrument

_____ Do not like sound of own voice

_____ Cannot tell direction of sound

_____ Battery Life

_____ Trouble understanding at a distance

_____Trouble understanding when two or more are talking

_____Trouble understanding in a crowd

Other (please specify): _____

General Medical History

Have you experienced any of the following major medical conditions (please circle all that apply):

AIDS	Cognitive Decline	Head Injury	Malaise	Sinusitis
Alzheimer's Disease	COPD	Heart Disease	Malaria	Stroke
Anemia	Dementia	Hepatitis	Measles	Thyroid Disease
Anxiety	Depression	High Blood Pressure	Meningitis	TIA
Appetite Change	Diabetes-Insulin Y/N	High Cholesterol	Mumps	Tonsillitis
Arthritis/rheumatoid	Diabetes-Type 1 or 2	High Fevers	Neurological Symptoms	Tooth Decay
Asthma	Diphtheria	HIV	Obesity	Typhoid
Bell's Palsy	Encephalitis	Influenza	Osteoporosis	Vascular Problems
Blood disorders	Fatigue	Kidney Disease-Stage __	Parkinson's	Worry
Cancer	Genetic Disorders	Loneliness	Rheumatoid	Other: _____
Chicken Pox	Headaches	Lung Disease	Scarlet Fever	

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, plastics, metals, etc.):

_____ Food _____

_____ Medications _____

_____ Plastic _____

_____ Metals _____

_____ Other _____

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months?

No Yes – How often have you used a tobacco product in the past 24 months? _____

Do you currently drink alcoholic beverages? No Yes – How often? _____

Do you currently use recreational drugs? No Yes – What drugs? _____ How often? _____

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.) _____