ADULT CASE HISTORY

Name: Age:_	Date:					
What is the primary reason for today's visit:						
Are you experiencing problems with your hearing? YES / NO						
Which Ear? BOTH / RIGHT / LEFT						
Has the hearing loss been: Gradual / Sudden / Fluctuating						
How long have you noticed problems with your hearing? Recently / 1-3 years / 4-6 years / 7-10 years / more than 10	years					
What do you think may have caused this?						
Have you had your hearing tested before? YES / NO if yes, when?						
What was the outcome of your previous hearing test? NO LOSS / MILD LOSS / HEARING AIDS RECOMMENDED						
Do you currently use a hearing aid(s)? YES / NO						
Have you ever used a hearing aid(s)? YES / NO						
Oo any members of your family have a hearing problem? YES / No	0					
Do you have a history of ear infections? YES / NO						
Have you had any of the following in the last six months? (circle all the Medically Diagnosed Ear Pathology / Ear Pain / Ear Drainage Pressure or Fullness in the ears						
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Have you ever had surgery on your ears? YES / NO						
Do you hear noises in your ears or head (tinnitus)? YES / NO Which ear? Both / Left / Right						
f yes, how often do you hear these noises? Constantly / Frequently / Occasionally / Very Seldom						
How would you describe the noise? **Ringing / Buzzing / Roaring / Screeching / Crickets / Pul.**	Isating					
Are you experiencing any problems with dizziness? YES / NO						
If yes, is your dizziness accompanied by the following? (circle all that Nausea / Vomiting / Noises in your ears / Loss of Conscio						



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