HEAR2UNDERSTAND
AUDIOLOGY SERVICES

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ADULT AUDIOLOGY CASE HISTORY FORM

Name:_____ Birthdate: _____

1. What is your primary complaint about your ears or hearing?

_____

2. What do you think caused your hearing problem?

_____

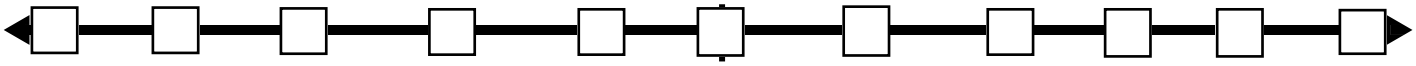
3. If you have a hearing loss, how long have you noticed this? _____

4. Which is your worse ear (if they are different): ☐ **Left** ☐ **Right**

5. Do you have difficulty understanding:

TV:	☐ **Yes**	☐ **No**
Telephone:	☐ **Yes**	☐ **No**
In Groups:	☐ **Yes**	☐ **No**

6. How important is it for you to improve how you hear, understand, or communicate with others ***RIGHT NOW*****?** (mark on the line)



0 (not at all important)

10 (Extremely important)

HISTORY

1. Have you ever had your hearing tested before? ☐ **Yes** ☐ **No**

2. Any drainage from your ear in the past 90 days? ☐ **Yes** ☐ **No**

3. Have you experienced any dizziness, balance problems, or falls? ☐ **Yes** ☐ **No**

4. Have you had any pain/discomfort in your ears within the past 90 days? ☐ **Yes** ☐ **No**

   If YES, rate your pain on a scale of 0 (no pain) to 10 (worst pain possible):_____

5. Have you ever lost hearing in your ear ***suddenly***? ☐ **Yes** ☐ **No**

6. Do you have any noises or ringing in your ears? ☐ **Yes** ☐ **No**

If present is it:

☐ **Left** ☐ **Right** ☐ **Both**
☐ **Constant** ☐ **Intermittent**
When did you first notice it? _____

7. Have you received any medical or surgical treatment for hearing loss? ☐ **Yes** ☐ **No**

8. Do you have trouble with arthritis, stiffness, numbness in your fingers? ☐ **Yes** ☐ **No**

9. Have you ever been exposed to loud noise? ☐ **Yes** ☐ **No**

If yes, describe the type of noise:_____

Did you use earplugs/muffs? ☐ **Yes** ☐ **No**

10. Is there a history of hearing loss in your immediate family? ☐ **Yes** ☐ **No**

If YES, who:_____

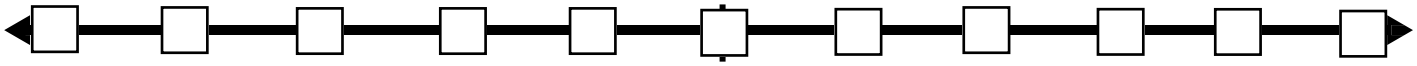
11. Medical problems (check all that apply):

☐ Infectious disease	☐ Diabetes	☐ Kidney failure
☐ High blood pressure	☐ Headache	☐ Head injury
☐ Pacemaker/defibrillator	☐ Heart problems	☐ Other:_____

12. Have you ever worn hearing aids? ☐ **Yes** ☐ **No**

If YES, how would you rate your experience from 0 (terrible) to 10 (great)?_____

13. How confident are you in your own ability to use and take care of hearing aids if they are recommended?



0 (not at all confident)

10 (Extremely Confident)

Signature: _____ Date:_____