ADULT Case History Form

Patient Name _____ **Date of Completion** _____/_____/_____

Date of Birth _____/_____/_____ **Gender** _____ **Primary Language** _____

E-MAIL address _____ (We value your privacy. Your personal information will be kept confidential and will never be sold to third parties. It will only be used for communications related to the services provided by Chippendale Audiology.)

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Race ☐ White ☐ African-American ☐ Asian ☐ American Indian ☐ Other _____

Ethnicity ☐ Hispanic or Latino

Current Employment ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Stay at Home Parent ☐ Student

Current Employer *(if applicable)* _____ Position _____

Highest Level of Education _____

Do you currently use tobacco products? ☐ Yes ☐ No

If yes, what? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless ☐ Other _____

If yes, amount per day? _____

Do you currently drink alcoholic beverages? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

MEDICAL HISTORY

Current Medications (if you wish us to copy your medications please provide list). ***Continue on back if needed.***

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Allergies (foods, medications, plastics, etc.) _____

_____

Other serious illnesses, surgeries, injuries, or hospitalizations and their approximate date(s) of occurrence

_____

_____

_____

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MEDICAL HISTORY con't

Have you experienced any of the following major medical conditions *(please check ALL that apply)*

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Encephalitis
- ☐ Fatigue
- ☐ Genetic Disorders
- ☐ Headaches
- ☐ Head Injury
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Fevers
- ☐ Influenza
- ☐ Malaise
- ☐ Malaria
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Stroke
- ☐ TMJ
- ☐ Thyroid
- ☐ Vascular Problems
- ☐ Other Problems _____

MEDICAL SYMPTOMS OR CONDITIONS *(please check ALL that apply)*

Eye problems *(such as blurred or double vision, pain)* ☐ Yes ☐ No

Nose, throat, or mouth problems *(such as trouble swallowing, nose bleeds, dental issues)* ☐ Yes ☐ No

Cardiovascular issues *(such as hypertension, chest pain, swelling, palpitations)* ☐ Yes ☐ No

Respiratory issues *(such as shortness of breath, cough, wheezing)* ☐ Yes ☐ No

Gastrointestinal issues *(such as nausea, vomiting, weight changes, diarrhea, pain)* ☐ Yes ☐ No

Musculoskeletal issues *(such as joint pain, swelling, recent trauma)* ☐ Yes ☐ No

Neurological symptoms *(such as numbness, headaches, tingling, seizures, muscle weakness)* ☐ Yes ☐ No

Psychiatric issues *(such as depression, anxiety, compulsions)* ☐ Yes ☐ No

Endocrine symptoms *(such as frequent urination, hot flashes)* ☐ Yes ☐ No

Hematologic/lymphatic symptoms *(such as bleeding gums, bruising, swollen glands)* ☐ Yes ☐ No

Allergic/immunologic symptoms *(such as hives, asthma, itching, immune deficiency)* ☐ Yes ☐ No

Comments related to symptoms or conditions listed above _____

_____

_____

_____

What motivated you to come to Chippendale Audiology today? _____

_____

_____

_____

_____

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AUDIOLOGIC HISTORY

Do you experience hearing loss? ☐ Yes ☐ No

If so, which ear? ☐ Right ☐ Left ☐ Both

If you experience hearing loss, which best describes it? ☐ Gradual ☐ Fluctuating ☐ Sudden

When did you first notice your hearing loss? _____

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

Have you ever had a hearing test? ☐ Yes ☐ No

If so, when _____

Which ear do you typically use to talk on the telephone? ☐ Right ☐ Left

Have you ever worn or tried a hearing aid or amplifier? ☐ Right ear ☐ Left ear ☐ Both ears

What type and/or style of hearing aid or amplifier _____

Please describe your experience _____

MEDICAL CONDITIONS ***(please check ALL that apply)***

☐ **Developmental disorder/delay** – If checked, please explain _____

_____

☐ **Dizziness or unsteadiness – *describe*** _____

If checked, is it accompanied by ☐ Vomiting ☐ Nausea ☐ Ear Noises

☐ **Ear deformity** – If checked ☐ Right ear ☐ Left ear ☐ Both ears

☐ **Ear drainage** – If checked ☐ Right ear ☐ Left ear ☐ Both ears

☐ **Ear pain** – If checked ☐ Right ear ☐ Left ear ☐ Both ears

☐ **Family history of hearing loss** – If checked, who is the family member _____

☐ **History of ear infections** – If checked ☐ Right ear ☐ Left ear ☐ Both ears

☐ **History of earwax buildup** – If checked ☐ Right ear ☐ Left ear ☐ Both ears

☐ **History of noise exposure** (Occupational/Recreational/Military/Other)

If checked, please describe _____

☐ **Previous ear surgery** – If checked ☐ Right ear ☐ Left ear ☐ Both ears

If so, when _____

☐ **Tinnitus** (ringing/noises in ears) – If checked ☐ Right ear ☐ Left ear ☐ Both ears

If so, frequency _____

☐ **Other – *describe*** _____

_____

_____

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HEARING HANDICAP SCREENING

Please select the most appropriate response.

PLEASE CHECK THE MOST APPROPRIATE ANSWER FOR EACH QUESTION, THEN TOTAL YOUR POINTS AT THE BOTTOM	Yes (4)	Sometimes (2)	No (0)
Does a hearing problem cause you to feel embarrassed when meeting new people?	☐	☐	☐
Does a hearing problem cause you to feel frustrated when talking to family members?	☐	☐	☐
Do you have difficulty hearing when someone speaks in a whisper?	☐	☐	☐
Do you feel handicapped by a hearing problem?	☐	☐	☐
Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	☐	☐	☐
Does a hearing problem cause you to attend lectures or religious services less often?	☐	☐	☐
Does a hearing problem cause you to have arguments with family members?	☐	☐	☐
Does a hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
Do you feel that difficulty with your hearing limits or hampers your personal or social life?	☐	☐	☐
Does a hearing problem cause you difficulty in a restaurant with relatives or friends?	☐	☐	☐

Total # of points in each column _____ _____ _____

TOTAL # OF POINTS _____

Please complete this form and bring it to your next appointment.

Submit Button

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