Adult Case History Form

Patient Name: _____ Date: _____

Date of Birth: _____ Gender: _____ Primary Language: _____

Email 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.)

Address:_____Phone: Cell_____

Phone: Home:_____

Marital Status: Single Married Divorced Widowed Domestic Partner

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

Do you currently use any tobacco products? Yes No

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)

Other serious illnesses, surgeries, injuries, or hospitalizations:

_____

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

- ☐**AIDS/HIV**
- ☐**Arthritis**
- ☐**Auto-immune**
- ☐**Blood Disorders**
- ☐**Cancer**
- ☐**Chicken Pox**
- ☐**Depression**
- ☐**Diabetes**
- ☐**Diphtheria**
- ☐**Encephalitis**
- ☐**Fatigue**
- ☐**Genetic Disorders**
- ☐**Headaches**
- ☐**Head Injury**
- ☐**Heart Problems**
- ☐**High Blood Pressure**
- ☐**High Cholesterol**
- ☐**High Fevers**
- ☐**Influenza**
- ☐**Malaise**
- ☐**Malaria**
- ☐**Measles**
- ☐**Meningitis**
- ☐**Mumps**

☐**Scarlet Fever**
☐**Stroke**
☐**TMJ**
☐**Thyroid**
☐**Vascular Problems**
☐**Vision Problems**
Other_____

**********What motivated you to come to Chippendale Audiology today? How did you find your way to our practice?**

_____

_____

Audiologic History

Are you concerned about any 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

Please describe your experience: _____

Please check all of the medical conditions that apply:

☐**Dizziness or unsteadiness**
☐**Ear deformity**
☐**Ear drainage**
☐**Ear pain**
☐**Family history of hearing loss**
☐**History of ear infections**
☐**History of earwax buildup**
☐**History of noise exposure (Occupational/ Recreational / Military / Other)**
☐**Previous ear surgery**
☐**Are you experiencing or concerned about memory loss or brain health? Yes No**
☐**Are you interested or concerned about how your cognitive health ability affects your sports or work performance? Yes No**
☐ **Did you know that improved hearing may positively impact brain health and memory? Yes No**
☐**Tinnitus/ringing/noises in ears**
If checked: Right ear Left ear Both ears
If so, frequency: _____
☐**Other (please describe):** _____

Hearing Handicap Screening (please select the most appropriate response):

- **Does a hearing problem cause you to feel embarrassed when meeting new people?**

  Yes No Sometimes
- **Does a hearing problem cause you to feel frustrated when talking to members of your family?**

  Yes No Sometimes
- **Do you have difficulty hearing when someone speaks in a whisper?**

  Yes No Sometimes
- **Do you feel handicapped by a hearing problem?**

  Yes No Sometimes
- **Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?**

  Yes No Sometimes
- **Does a hearing problem cause you to attend lectures or religious services less often than you would like?**

  Yes No Sometimes
- **Does a hearing problem cause you to have arguments with family members?**

  Yes No Sometimes
- **Does a hearing problem cause you difficulty when listening to TV or radio?**

  Yes No Sometimes
- **Do you feel that any difficulty with your hearing limits or hampers your personal or social life?**

  Yes No Sometimes
- **Does a hearing problem cause you difficulty when in a restaurant with relatives and friends?**

  Yes No Sometimes

Yes = 4 points

Sometimes = 2 points

No = 0 points

Total Points:_____

Patient Name:_____