Adult Case History Questionnaire

Revised 03312014

Patient Name: _____ **Date**: _____

Reason for today's appointment (primary complaint about your ears): _____
_____

Allergies to any medications, plastics, etc. : _____

Place of employment: _____
What do you do: _____
Hobbies, interests: _____

Have you ever been exposed to loud noise? ☐ Yes ☐ No If yes, describe the type of noise: _____
_____ Did you use ear protection? ☐ Yes ☐ No
Is there a family history of hearing loss? ☐ Yes ☐ No Who: _____
Have you ever had ear surgery? ☐ Yes ☐ No
What was the surgery? _____
Have you ever had any head/ear trauma? ☐ Yes ☐ No What was the trauma? _____
_____

Have you ever taken medication that had a toxic effect on your hearing? ☐ Yes ☐ No
What was the toxic medication? _____
*Have you experienced any drainage from your ears within the last 90 days? ☐ Yes ☐ No
Which ear did you have drainage? ☐ Right ☐ Left
*Do you suffer from pain or discomfit in your ears? ☐ Yes ☐ No ☐ Right ☐ Left
Do you have temporomandibular joint (TMJ) disorder? ☐ Yes ☐ No ☐ Right ☐ Left
Do you have a congenital or traumatic deformity of the ear? ☐ Yes ☐ No Please explain:
_____
_____

Do you have ringing, roaring, buzzing (tinnitus)? ☐ Yes ☐ No ☐ Right ☐ Left
If present, is it: Constant _____ Intermittent _____ When did you first notice your tinnitus? _____
What does it sound like? _____
Do you have significant cerumen (earwax) accumulation in your ear canal? ☐ Yes ☐ No ☐ Right ☐ Left

*Do you suffer from acute or chronic dizziness? ☐ Yes ☐ No
Are you diabetic? ☐ Yes ☐ No
Do you have high blood pressure? ☐ Yes ☐ No Is it controlled by medication? ☐ Yes ☐ No
Do you have a pacemaker? ☐ Yes ☐ No
*Do you have headaches? ☐Yes ☐No
*Do you have blurry vision? ☐Yes ☐No
*Do you have nausea or vomiting? ☐Yes ☐No
Do you smoke? ☐Yes ☐No; Have you ever smoked? ☐Yes ☐No; How long? _____
How many packs a day? _____

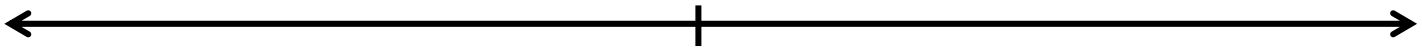
When was your last hearing test? _____
Where did you have your hearing tested?_____
Was your hearing normal? ☐Yes ☐No
Have hearing aids ever been recommended? ☐Yes ☐No
Have you ever worn hearing aids? ☐Yes ☐No
*Have you ever experienced sudden hearing loss? ☐Yes ☐No
Does your hearing limit or hamper your personal or social life? ☐Yes ☐No

Please list the three most difficulty listening situations for you:
1. _____

2. _____

3. _____

How important is it for you to improve how you hear, understand, or communicate with other right now. (please mark the line)



0 10
(not at all important) (extremely important)

Please list all major surgeries in the past 10 years: _____
_____
_____

Please list any serious illnesses in the past 10 years: _____
_____
_____

Current medications: Please use an additional page if necessary

NAME OF DRUG	DOSE	HOW OFTEN (ex. once per day)	ROUTE (example orally)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			