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 (not at all important)                                                                 10 (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

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<th>DOSE</th>
<th>HOW OFTEN (ex. once per day)</th>
<th>ROUTE (example orally)</th>
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