Adult Case History Questionnaire

Revised 09302021

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

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 discomfort 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 much? _____ How long? _____

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

Do you have a family history of hearing loss? ◯Yes ◯No

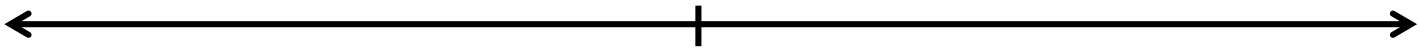
Please list the three most difficult listening situations for you:

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)



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(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: _____
_____

Are you concerned about memory loss or forgetfulness? ◯Yes ◯No

Did you know that hearing loss can affect your memory/concentration/decision-making? ◯Yes ◯No

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.			