Whisper Hearing Centers

Hear from the experts.

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ADULT CASE HISTORY

NAME: _____ DOB: _____ DATE: _____

AUDIOLOGIST: _____ PHYSICIAN: _____

REASON FOR VISIT: _____

1. Are you aware of hearing loss? Y N
   If yes, how has the loss occurred? Suddenly Gradually
2. Do you hear better out of one ear? Y N
   If so, which ear? Right Left About the same
3. Does anyone in your family have hearing loss other than natural aging? Y N
   If yes, please explain _____
4. Do you have history of loud noise exposure? (job, hunting, music, etc) Y N
5. Do you have history of ear infections? Y N
   If yes, what treatment was given? _____
6. Have you ever had surgery on your ear(s)? Y N
   If yes, please explain _____
7. Do you ever feel a fullness/pressure/clogged sensation in your ear(s)? Y N
   If so, can you relieve the feeling? _____
8. Do you hear sounds (tinnitus) in your ears? Y N
   If yes, please explain _____
9. Do loud sounds cause you discomfort? Y N
10. Do you ever have problems with your balance or feel the room spinning? Y N
    If yes, please explain _____
11. Do you grind your teeth or clench your jaw? Y N
12. Do you have sinus/allergy problems? Y N
13. Have you ever had significant head trauma? Y N
14. Have you ever had facial numbness/tingling/weakness? Y N
15. Have you recently noticed cold sores or bodily rashes? Y N
16. Have you ever been on any medication known to be toxic to hearing? Y N
17. Do you have a history of wax buildup in your ears? Y N
18. Has your hearing ever been tested? Y N
    If yes, by whom, when, and results: _____
    _____
19. Do you wear hearing aids? Y N
    If yes, for how long and type? _____
20. Would you be interested in learning more about hearing aids if you are a candidate? Y N
21. Please list any medications (including non-prescriptions) you are currently taking or have taken recently;

    _____

    _____

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