



Whisper Hearing Centers

Hear from the experts.

www.whisperhearingcenters.com

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; | | | | | |

