Whisper Hearing Centers
Hear from the experts.

ADULT CASE HISTORY

NAME: _____ **DOB:** _____ **DATE:** _____

1. Are you aware of hearing loss? **Yes** **No**
   If yes, how has the loss occurred? **sudden** **gradual**
   If yes, how long have you noticed this problem? _____
2. In which ear do you hear the best? **Right** **Left** **Same in both ears**
3. Does anyone in your family have hearing loss other than natural aging? **Yes** **No**
   If yes, please explain _____
4. Do you have history of loud noise exposure? (occupational, military, gun fire, music, etc.) **Yes** **No**
5. Do you have history of ear infections or drainage from your ears? **Yes** **No**
   If yes, what treatment was given? _____
6. Have you ever had surgery on your ear(s)? **Yes** **No**
   If yes, please explain _____
7. Do you ever feel a fullness/pressure/clogged sensation in your ear(s)? **Yes** **No**
   If so, can you relieve the feeling? _____
8. Do you hear sounds (tinnitus, ringing, buzzing) in your ears? **Yes** **No**
   If yes, which ear? **Right** **Left**
   How frequent? _____
   Please describe the sound: _____
9. Have you ever experienced dizziness, unsteadiness, imbalance or vertigo? **Yes** **No**
   If yes, please describe: _____
   Frequency of occurrence: _____
   If yes, is it accompanied by any of the following symptoms: (Please circle)
   Nausea **Ringing or noises in your ear** **Hearing loss** **Visual disturbances** **Other**
10. Have you fallen within the last 12 months? **Yes** **No**
    If yes, how many falls have you experienced in the last 12 months? _____
    If you have fallen, have you been injured? **Yes** **No**
    Please describe your injury: _____
11. Do you grind your teeth or clench your jaw? **Yes** **No**
12. Have you ever had significant head trauma? **Yes** **No**
13. Have you ever had facial numbness/tingling/weakness? **Yes** **No**
14. Do you have a pacemaker? **Yes** **No**
15. Have you ever been on any medication known to be toxic to hearing? **Yes** **No**
16. Have you used a tobacco product one or more times in the last 24 months? **Yes** **No**
    If yes, what do you use: **Cigarettes** **Cigars** **Pipe** **Smokeless** **Other:** _____
    If yes, amount of use per day: _____
17. Do you have a history of wax buildup in your ears? **Yes** **No**
18. Has your hearing ever been tested? **Yes** **No**
    If yes, when? _____
    What were the results? _____
19. Have you ever worn hearing aids? **Yes** **No**
    If yes, for how long and type? _____
    Do you wear it regularly? **Yes** **No**
20. Whom should we thank for referring you to WHC? _____

MEDICATION LIST

NAME: _____ **DOB:** _____ **DATE:** _____

Please list any medications you are currently taking or have taken recently. (Please include prescription, over the counter, herbals, and vitamin/dietary supplements.)

DRUG NAME	DOSAGE (mg)	FREQUENCY (how often)	ROUTE (into body)