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ADULT CASE HISTORY

NAME:______________________________________ DATE:_______________

Please give a brief explanation of your hearing problem:____
____
____

Please answer the following questions regarding your hearing history.

1. Have you ever had a hearing test? YES NO
   If yes, When? _______________________ Where?_____________________________

   Results:____

2. Do you have a better ear? YES NO

3. Does your hearing fluctuate? YES NO

4. Does anyone in your family have a hearing loss that was not acquired through aging? YES NO
   If yes, who? ________________________ What age?___________

5. Do you suffer from head noise (ie: ringing or buzzing)? YES NO
   If yes, can you tell where? RIGHT MID LEFT

6. Have you ever experienced dizzy spells? YES NO

7. Have you ever been exposed to noise - recreational or work related? YES NO

8. Do you have a history of any of the following medical problems? (Please circle)

   Ear Infections | Upper Respiratory Infections
   Kidney | Diabetes
   Head Injury | High Blood Pressure

9. Are you currently taking medication?
   If yes, please indicate:____

10. Have you ever worn a hearing aid? YES NO RIGHT LEFT

11. How often do you wear it?____