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ADULT CASE HISTORY

Name_________________________________ Date____________________

1. Do you feel that you have a hearing loss? YES NO
   If yes, how long ___________
   What do you think caused the loss? ___________________________________

2. Do you feel one ear is better than the other? YES NO
   If so, which ear Right___ Left____

3. In what situations do you have difficulty hearing? (one on one conversation, groups, work, church, TV, etc.)____
   ____

4. Have you worn a hearing aid? YES NO

   If so, how long____________________________

5. Have you ever received medical treatment for significant ear problems YES NO
   ____

6. Have you had recent ear pain or drainage? YES NO

7. Do you have any allergies? YES NO

8. Do you ever have noises in your ear? YES NO

9. Have you experienced dizziness in the past 90 days? YES NO

11. Have you ever been exposed to high noise levels? YES NO

12. Does anyone in your family have a hearing loss? YES NO

    If so, what caused it?______________________________

13. Do you have any significant health problems or physical handicaps? YES NO

14. What questions or problems would you like help with today? _______________

    ____

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