

Adult Case History Form

Patient Name _____ Age _____ Date _____

1. Chief complaint(s):
- _____ Decreased Hearing or Understanding (Right/Left/Both)
 - _____ Fullness/Pressure in Ear (Right/Left/Both)
 - _____ Dizziness/Vertigo
 - _____ Tinnitus (Ringing or Buzzing) (Right/Left/Both) (Steady or Pulsing)
 - _____ Sudden Change in Hearing (Right/Left/Both)
 - _____ Pain/Discomfort in Ear (Right/Left/Both)
 - _____ Drainage/Discharge from Ear (Right/Left/Both)

2. How long have you noticed this difficulty? _____ (Years/Months/Days) (Sudden/Gradual)

3. Is one ear better than the other? (Right/Left/Neither)

4. Is this problem due to a work-related injury/exposure? (Yes/No)
If yes, please explain and give date of injury:

5. Have you ever been exposed to loud noise? (Yes/No)
If yes, please check all that apply:

_____ Farm Machinery _____ Music _____ Firearms _____ Factory Noise
_____ Power tools _____ Military _____ Jet engines Other: _____

6. Do your ears produce a buildup of wax? (Yes/No)

7. Have you seen a physician about your ears/hearing? (Yes/No)
If yes, when and where? _____

8. Have you ever had a **hearing test** before? (Yes/No)
If yes, how long ago and what were the results? _____

9. Have you had **surgery, chemotherapy, or radiation** that affected your hearing or balance? (Yes/No)
If yes, what type and when? _____

10. Is there a history of hearing loss in your family? (Yes/No)
If yes whom? _____

11. Do you wear a pacemaker? (Yes/No)

12. Do you wear hearing aids? (Yes/No) (Right/Left/Both)
If yes how long? _____ How would you rate them on a scale of 1-10? _____

13. Who referred you to us today: _____

Please check (√) if you have experienced any of the following:

- Tubes in eardrum
- Ear drainage/bleeding
- Swimmer's Ear
- Ear Surgery
- Popping sensation in the ear
- Sensitivity to loud noises
- Fluid behind the eardrum
- Fluctuating/sudden hearing loss
- Abnormal ear structure
- Dizziness/Vertigo
- Ear infection within last year
- Wax removal

Describe: _____

Please check (√) if you have been diagnosed with any of the following:

- Otosclerosis
- Cholesteatoma
- Bell's palsy
- Labyrinthitis
- Meniere's disease
- Barotrauma
- Permanent hearing loss
- Ossicular dislocation/fixation
- Acoustic neuroma

Describe: _____

Please check (√) if you have experienced any of the following:

- Heart disease
- Mumps
- Kidney or renal problems
- Stroke/TIA
- Meningitis
- Chronic sinus infections
- Diabetes
- Measles
- Environmental allergies
- High blood pressure
- Scarlet fever
- Cancer
- Hypothyroidism
- HIV/AIDS
- Radiation/chemotherapy
- Asthma
- Tuberculosis
- Long term IV antibiotics
- Mental illness
- Head trauma
- Depression or anxiety
- Hepatitis A, B or C
- Loss of Consciousness
- Migraines
- Liver Problems
- Exposure to chemicals/solvents

14. Please indicate if you currently take medications for any of the following:

_____ Blood pressure _____ Diuretics (fluid pills) _____ Aspirin
_____ Blood thinners _____ Cholesterol

15. Please list your current prescriptions/reason for taking:

- _____
- _____
- _____
- _____
- _____
- _____