19465 Deerfield Ave.
Suite 201
Lansdowne, VA 20176

703-858-7620 (Voice/TDD)
703-858-7657 (fax)
www.speechhearing.org

ADULT CASE HISTORY FORM
AUDIOLOGY

Name: ____ **Email Address:** ____

Date of Birth: _______________________ **Age:**_________ **Gender:**________

Address: ____

____

Primary Phone:____ **Secondary Phone:** _____________________________

Ethnicity: African American Asian Caucasian Hispanic/Latino Other______________________

Primary Insurance: ____Phone: __________________________________

ID# ____

Card Holder Name:____Card Holder DOB _________________________

Secondary Insurance:____Phone: __________________________________

ID# ____

Card Holder Name:____Card Holder DOB __________________________

Who referred you? ____

Primary Care Doctor or ENT:

Name: ____ Phone: ____

Address: ____ FAX: ____

Yes No Would you like us to fax a copy of your audiogram to them

MEDICAL HISTORY:

Yes No Have you seen a doctor in the past six months? (Dr.________________________)

Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, give date _______________________

Yes No Have you ever had your hearing tested?
If yes, give date_______________________by whom _________________________

Yes No Have you ever had any type of ear surgery?
If yes, type of surgery_______________________(Dr.________________________)

Yes No Do you take medicine every day?
For what condition? ____

Yes No Do you have any other medical conditions?
If yes, explain ____

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Yes No Are you hypertensive?
Yes No Have you ever suffered a head injury?
Yes No Nervous?
Yes No Blurred vision?
Yes No Have a heart condition?
Yes No Facial numbness?
Yes No Dizziness/vertigo/off balance?

SOCIAL HISTORY:

Yes No Have you ever been exposed to loud noise, either recently or in the past?
(if yes, mark those that apply) Farm Machinery, tools, Music, Military, shooting,
Other: _______________

ABOUT YOUR EARS: Do you have any of these symptoms?

Yes No Deformity of the ear
Yes No Drainage from the ear or fungal infections
Yes No Sudden or rapid loss of hearing in the past 90 days
Yes No Do you experience fullness in your ears
Yes No Have you ever seen a doctor for wax removal
Yes No Do you ever have pain in your ears
Yes No Do you experience tinnitus (ringing/roaring/buzzing in the ears)
If yes, please describe: ____

ABOUT YOUR HEARING: Which is your poorer ear? Same Right Left

Do you experience difficulty with the following?

Yes No Understanding conversation
Yes No Hearing in a crowd
Yes No Hearing by telephone
Yes No How long have you had a hearing problem? ______________________________
Yes No Does anyone else in your family have a hearing problem?
What relationship? ____

Yes No Do you now or have you ever worn a hearing aid?
If yes, when were you last fit with hearing aids? _______________________________

If hearing aids are recommended for you:
(please rank the following in order of importance to you 1-4, one being most important)

______Improved hearing in quiet ______Cosmetic appearance
______Improved hearing in noise ______Expense

How motivated are you currently to seek improvement in your hearing?

______Not Motivated
______Slightly Motivated
______Extremely Motivated

Signature____ Date ___________________________

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