DuPage Medical Group- Audiology Department
Adult Case History Form

Patient Label Here

Name:_____
DOB: _____
Occupation:_____
Referring Physician: _____

Primary Concern: _____
_____
_____
_____

1. How would you best describe your hearing? More than one may apply.
   - ○ Hearing is fine with no concerns
   - ○ Able to hear but not clearly
   - ○ Difficulty hearing in noisy environments
   - ○ Difficulty hearing from a distance
   - ○ Difficulty hearing in group situations
   - ○ Unable to hear

2. Do you feel that your hearing is better in one ear versus the other? Yes No
   If yes, which ear is better? ○Right ○Left

3. Have you previously had a diagnostic hearing test? Yes No
   If yes, how long ago? _____ Results? _____

4. Have hearing aids ever been recommended? Yes No
   Worn? Yes No Which ear? ○Right ○Left ○Both
   How long have you used hearing aids? _____ Age of current aids? _____
   Any concerns regarding your current hearing aids? _____

5. Do you ever experience noises in either ear (ringing, hissing, buzzing)? Yes No
   If yes, describe: _____
   When did the sound begin? _____
   How frequently? ○Rarely ○Occasionally ○Daily ○Constantly, sound does not stop
   Where? ○ Right Ear ○ Left Ear ○ Both Ears ○ Can't tell location

6. Do you have a history of ear infections? Yes No
   If yes, when was the last infection? _____

7. Have you ever had ear surgery? Yes No
   Is yes, what surgery? _____

8. Is there a family history of hearing loss? Yes No
   If yes, who? _____
   If known, why? _____

9. Have you ever been exposed to loud noise, recently or in the past? Yes No
   - ○ Firearms
   - ○ Factory work
   - ○ Military equipment
   - ○ Power tools
   - ○ Music
   - ○ Farm equipment
   - ○ Explosions
   - ○ Heavy equipment
   - ○ Motorcycles/ recreational vehicles
   - ○ Other _____

(OVER →)

DuPage Medical Group- Audiology Department
Adult Case History Form

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

○ Excessive ear wax	○ Ear drainage/bleeding	○ Swimmer's Ear
○ Ear pressure/fullness	○ Popping sensation in the ear	○ Ear pain
○ Fluctuating hearing loss	○ Fluid behind the eardrum	○ Dizziness/Vertigo
○ Sensitivity to loud noises		

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

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

Medical History:

1. Have you ever used tobacco products of any kind? Yes No

2. How many alcoholic drinks/week do you consume? _____

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	○ Visual Problems	○ Head trauma
○ Depression or anxiety	○ Hepatitis A, B or C	○ Loss of Consciousness
○ Migraines	○ Liver Problems	○ Exposure to chemicals/solvents

Please list your current prescriptions:

	Medication	Reason
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

* If needed, please list additional medications on separate piece of paper.

→ _____ _____
Signature of person completing history Date

→ _____
Relationship to patient