Salem Audiology Clinic, Inc.

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ADULT CASE HISTORY

Name: _____ Date of Birth: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ Occupation: _____ Spouse: _____

Physician: _____ Clinic address, if known: _____

E-mail Address: _____

How did you hear about us? _____

* * All contact information, including e-mail address, will be used strictly for issues related to today's visit and any necessary future contact. It will not be disclosed to outside sources beyond the scope of our patient privacy policy. Your initials: _____

What is your goal for today's appointment?? _____

_____

- Ear, Hearing & Noise Exposure History -

(Please circle appropriate answer and provide more information where necessary.)

Known Hearing Loss? Yes No
Right Left Both
How long? _____
Gradual? Sudden? Fluctuating?

Past Ear Surgery? Yes No
Right Left Both
Describe: _____

Recent Ear Pain? Yes No
Right Left Both
Describe: _____

Recent Ear Drainage? Yes No
Right Left Both
Describe: _____

Full/plugged sensation? Yes No
Right Left Both
How long? _____

Tinnitus (ringing/other noises in ears)? Yes No
*If yes, please answer more questions on reverse.

Dizziness/Balance problems? Yes No
Does the room spin? Yes No
How long have you had problem? _____
How frequently does it occur? _____
Duration of an episode? _____

Family History of Hearing Loss? Yes No
Who? _____

Have you ever worked in noise? Yes No
Military? Yes No
Describe: _____

Noisy Hobbies:
Firearm use? Yes No
Loud music/concerts? Yes No
Other: _____

- Other Medical History -

(Please circle if you have or have had any of the following)

Allergies
Cancer
Cerebral Palsy
Diabetes
Head Injury
Heart Attack
High Blood Pressure
HIV/AIDS
Kidney Disease
Meningitis
Multiple Sclerosis
Mumps
Stroke
Other communicable disease

Other Significant Health Issues: _____
_____
_____
_____
_____
_____

Medications: _____
_____
_____
_____
_____
_____

**** PLEASE TURN OVER ****

HEARING LOSS ASSESSMENT

Hearing Handicap Inventory

	Yes	Sometimes	No
1. Does your hearing problem cause you to feel embarrassed?	☐	☐	☐
2. Does your hearing problem cause you to feel frustrated when talking to family?	☐	☐	☐
3. Do you have difficulty hearing when someone speaks in a whisper?	☐	☐	☐
4. Do you believe your hearing problem has affected work or similar situations?	☐	☐	☐
5. Does your hearing problem cause you difficulty when visiting friends or family?	☐	☐	☐
6. Does your hearing problem cause you to avoid large group situations?	☐	☐	☐
7. Does your hearing problem cause you to have arguments with friends or family?	☐	☐	☐
8. Does your hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
9. Does your hearing problem hamper your personal or social life?	☐	☐	☐
10. Does your hearing problem cause you difficulty when in a noisy situation like a restaurant or party?	☐	☐	☐

Please list four specific <u>goals</u> for improving your hearing:

1. _____ 3. _____

2. _____ 4. _____

If you have worn hearing aids before, please answer the following:

HEARING AID HISTORY

How long have you worn hearing aids? _____

Where did you purchase them? _____

Were they purchased through Private Insurance, Self-Pay, or Medicaid?_____

How satisfied are you with your hearing aid(s) in the following situations?

At home, one-on-one conversations	□ Good	□ OK	□ Poor
In background noise (i.e. restaurants)	□ Good	□ OK	□ Poor
On the Telephone	□ Good	□ OK	□ Poor
On a cellular telephone	□ Good	□ OK	□ Poor
Riding in the car	□ Good	□ OK	□ Poor
At Work	□ Good	□ OK	□ Poor
Television	□ Good	□ OK	□ Poor
In a large room	□ Good	□ OK	□ Poor

Are you here to replace your hearing aids if something better is available? Yes Maybe No

If you answered "yes" that you have tinnitus (ringing or other sounds in your ears), please answer the following:

TINNITUS ASSESSMENT

<u>Description of your tinnitus</u>

What does it sound like?

☐ Ringing ☐ Roaring ☐ Rushing
☐ Hissing ☐ Pulsating ☐ Warbling
☐ Musical ☐ Other: _____

How often do you hear it?:

☐ Rarely ☐ Occasionally ☐ Constantly

Duration:

☐ Rare ☐ Occasional ☐ Constant

Loudness:

☐ Very Loud ☐ Loud ☐ Present

<u>How Does Your Tinnitus Affect You?</u>

Make you irritable or nervous?	☐ Yes	☐ No
Make you tired or stressed?	☐ Yes	☐ No
Affect your sleep habits?	☐ Yes	☐ No
Make it difficult to relax?	☐ Yes	☐ No
Make it difficult to concentrate?	☐ Yes	☐ No
Interfere with your work?	☐ Yes	☐ No
Interfere with social activities?	☐ Yes	☐ No
Make you depressed?	☐ Yes	☐ No
Affected you otherwise?	☐ Yes	☐ No

Describe: _____

_____