Memphis Speech and Hearing Center
Audiology Adult Case History

HISTORY:

Describe the problems you are having with your hearing or balance: ____________________

____

When did you (or others) first notice the problem? ____________________

____

Have you had your hearing tested recently? ☐ Yes ☐ No

PHYSICAL HISTORY:

Do you wear glasses/contacts? ☐ No ☐ Glasses ☐ Contacts ☐ Both

Please describe past illness/injury/hospitalization information below including the date of the illness, a description of the illness, and whether or not it required hospitalization: ____________________

____

____

____

Have you ever been diagnosed with memory problems? ☐ Yes ☐ No

ALLERGIES:

Please list all allergies below (medications, Latex, food, environmental, etc.)

____

____

____

____

MEDICATIONS:

Have you ever taken medicine that may harm your hearing? ☐ Yes ☐ No

Please list all medications (prescribed and over the counter) that you are currently taking on a regular basis. Include the medication's name, dosage, how often it's taken, and the route of administration.

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____

If additional space is needed to list all medications, please notify staff for an additional form.

HEARING HISTORY:

Have you had a hearing test? If yes, in which ear?	☐ Right	☐ Left	☐ Both
When was the hearing test?	____________________		
What were the results of the hearing test?	____________________		
Which ear(s) do you have problems hearing?	☐ Right	☐ Left	☐ Both
Has your hearing loss been?	☐ Gradual	☐ Sudden	☐ Fluctuating
Has a hearing aid ever been recommended for you?	☐ Yes	☐ No	
Do you wear a hearing aid?	☐ Yes	☐ No	
Which ear?	☐ Right	☐ Left	☐ Both

In what ways does your hearing loss affect your daily life? ____________________

____

If yes, for how long? ____________________ Type of hearing aid: ____________________

Has anyone in your family had a hearing loss? ☐ Yes ☐ No

Do you have difficulty hearing in the situations listed below?

On the telephone	☐ Yes	☐ No	Children talking	☐ Yes	☐ No
Watching television	☐ Yes	☐ No	Men talking	☐ Yes	☐ No
At restaurants	☐ Yes	☐ No	Women talking	☐ Yes	☐ No

One-on-one at home ☐ Yes ☐ No At Church ☐ Yes ☐ No
Group situations ☐ Yes ☐ No

Have you ever been treated for ear infections? ☐ Yes ☐ No If yes, when? ________________________
Have you ever been diagnosed with an ear disorder or had ear surgery? ☐ Yes ☐ No
Please explain: ____
Do you have any noises in your ears? If yes, in which ear? ☐ Right ☐ Left ☐ Both
Do you have episodes of dizziness? ☐ Yes ☐ No
Do you have any pain or fullness in your ears? ☐ Yes ☐ No
Have you ever been exposed to loud noises? ☐ Yes ☐ No
Please indicate those noises you have been exposed to:
☐ Gunfire ☐ Explosions ☐ Factory Noise ☐ Power Tools ☐ Motorcycle ☐ Aircraft
☐ Power Mower ☐ Loud Music ☐ Military Service ☐ Heavy Equipment ☐Other ____________________
Have you ever worn, or do you currently use hearing protection? ☐ Yes ☐ No

Please add any other concerns you may have that have not been addressed: ________________________________

INTERPRETIVE SERVICES:

Client preferred language ☐ English ☐ Spanish ☐ Vietnamese ☐ Arabic ☐ Mandarin ☐ Other
☐ American Sign Language ☐ Communication Assistive Devices ☐ Unknown
Person with client preferred language ☐ English ☐ Spanish ☐ Vietnamese ☐ Arabic ☐ Mandarin ☐ Other
☐ American Sign Language ☐ Communication Assistive Devices ☐ Unknown
☐ No primary caregiver identified

SOCIAL HISTORY: *these questions must be addressed for patients 10 years old or older.

History of tobacco use: ☐ Never smoked ☐ Former smoker (circle ceased smoking in last 30 days or >30 days)
☐ Current every-day smoker ☐ Current some day smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker
☐ Secondhand smoke exposure ☐ Type of tobacco ☐ Packs per day ________
Have you abused substances in the past 30 days? ☐ Yes ☐ No
If yes, type of substance: ☐ Heroin ☐ Inhalants ☐ Marijuana ☐ Methamphetamine ☐ Narcotics
☐ Sedatives ☐ Cocaine ☐ Ecstasy ☐ Hallucinogenic ☐ Ketamine ☐ Other ______________________
Substance amount ______________ Date of last use: ___ / _____ / _____
Alcohol use/frequency ☐ None ☐ <12 drinks/week ☐ 12+ drinks/week ☐ 5+ drinks per occasion once/week
Alcohol amount _________________ When was your last drink? ____________________

Person completing this form: ____