**UNIVERSITY OF NORTH TEXAS**
**SPEECH AND HEARING CENTER**

## Adult Case History—Audiology

Please fill out this form completely. Use NA for "not applicable," CR for "can't remember," and DK for "don't know."
Name_____ Date_____
Date of Birth _____ Age_____ Sex_____ Phone: Home_(_____)_____
Occupation_____ Work_(_____)_____
Address_____
City State Zip
Referred by_____

Chief complaint or reason for referral_____
_____

1. Have you had your hearing evaluated previously? yes_____ no_____
   If so, when and what were the results?_____

2. Do you have hearing loss? yes_____ no_____
   If so, in which ear? right_____ left_____ both_____ When did it begin?_____
   Has it become worse? yes_____ no_____ Does it fluctuate or vary? yes_____ no_____
   What caused the hearing loss? _____

3. Do you hear head noise, ringing, or buzzing in the ears? yes_____ no_____
   If so, in which ear do you hear it? right_____ left_____ both_____
   Describe how it sounds_____

4. Is there a family history of hearing loss? yes_____ no_____
   If so, who had hearing loss?_____
   What was the age it began?_____ What caused the hearing loss?_____

5. Have you had ear infections? yes_____ no_____
   If so, in which ear? right_____ left_____ both_____ Have you had drainage? yes_____ no_____
   What age did they begin? _____ How many have you had? _____
   When was the last infection?_____
   What kind of treatment have you had? _____

6. Have you had dizziness or vertigo? yes_____ no_____
   If so, describe your symptoms _____

7. Have you had surgery on your ears? yes_____ no_____
   If so, which ear? right_____ left_____ both_____
   What type of surgery did you have? _____
   When and where was your surgery? _____
   Who performed the surgery? _____

*Please answer the questions on the reverse side of this form.*

8. Have you had an ear injury? yes_____ no_____
If so, describe _____

9. Have you had a head injury? yes_____ no_____
If so, describe _____

10. Check any listed diseases you have had.
Measles_____ mumps_____ meningitis_____ kidney infection_____ malaria_____
Diabetes_____ circulatory problems_____ other_____
Please list any medications taken for the above: _____

11. What medications do you currently take? _____
_____

12. Have you had a very high temperature? yes_____ no_____
If so, how high was it? _____ How long did it last?_____

13. Have you had a history of loud noise exposure? yes_____ no_____
If so, was it at work? yes_____ no_____ What type of work? _____
How long were you exposed? _____ Did you use ear protection? yes_____ no_____
Was it during military service? yes_____ no_____ What type of noise? _____
How long were you exposed? _____ Did you use ear protection? yes_____ no_____
Was it during hobbies? yes_____ no_____ What type of hobbies? _____
How long were you exposed? _____ Did you use ear protection? yes_____ no_____

14. Check your primary means of communication.
Spoken English_____ Spanish_____ other language_____ sign language_____
Writing_____ other_____

15. Check the situations where you have difficulty understanding speech.
In most situations_____ in groups_____ in noise_____ on the telephone_____
All the time_____ most of the time _____ often_____ occasionally_____

16. Which ear do you normally use on the phone? right_____ left_____

17. Have you used a hearing aid previously? yes_____ no_____
If so, in which ear? right_____ left_____ both_____ What type of aid? _____
How long did you use it? _____ How did it benefit you? _____

18. If you have not worn a hearing aid, do you think you might need one? yes_____ no_____

Additional comments:

_____
Signature

_____
Relationship (if other than the patient)

*Please answer the questions on the reverse side of this form.*