CENTER FOR HEARING & SPEECH

ADULT CASE HISTORY FORM - **AUDIOLOGY**

NAME: _____ DATE OF BIRTH: _____

GENERAL INFORMATION

What brings you to the clinic? _____

Do you suspect you have a hearing loss? ☐ Yes ☐ No

If yes, how long have you noticed the problem? _____

With which ear do you hear the best? ☐ Right ☐ Left ☐ Both same

What do you feel is the cause of your hearing problem? _____

Describe the progression of your hearing problem. ☐ Fluctuating ☐ Gradual ☐ Rapidly changing ☐ Sudden loss

Have you ever been exposed to occupational (military service, factory) or recreational noise (hobbies)? ☐ Yes ☐ No

If yes, please describe: _____

If yes, was hearing protections used? ☐ Always ☐ Sometimes ☐ Never

Does anyone in your family have a hearing problem? ☐ Yes ☐ No ☐ Unknown

If yes, please describe: _____

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

If yes, how long ago? _____

What were the results? _____

Have you ever seen a physician for your hearing? ☐ Yes ☐ No

If yes, please explain: _____

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MEDICAL HISTORY

Have you had earaches/drainage from your ears within the last 3 months? ☐ Yes ☐ No

Have you ever had a feeling of fullness or stuffiness in your ears? ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both

How often do you feel it? _____

Please describe the feeling? _____

Have you ever had any tinnitus (ringing, buzzing, roaring) in your ears? ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both How Frequently? _____

Is it bothersome? ☐ Yes ☐ No ☐ Sometimes

Please describe the sounds. _____

Do you experience facial weakness, numbness or tingling? ☐ Yes ☐ No ☐ Sometimes

If yes, please describe: _____

Have you ever had medical/surgical treatment for your head, neck, or ears? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever experienced head trauma? ☐ Yes ☐ No

If yes, please describe: _____

Please list any medication you are taking or have taken recently.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you had any of the following? (CHECK ALL THAT APPLY)

☐ Arthritis	☐ Diabetes – Type II	☐ Multiple Sclerosis
☐ Allergy/sinus problems	☐ Hepatitis	☐ Pacemaker
☐ Bell's Palsy	☐ High Blood Pressure	☐ Parkinson's Disease
☐ Cancer	☐ Scarlet Fever	☐ HIV
☐ Seizures	☐ Dementia/Alzheimer's	☐ Measles
☐ Stroke/TIA	☐ Meningitis	☐ Depression/Anxiety
☐ Tuberculosis	☐ Diabetes – Type I	☐ Mumps

HEARING HISTORY

Do you have difficulty hearing/understanding during any of the following activities? (CHECK ALL THAT APPLY)

☐ Watching TV ☐ Dining in restaurants ☐ Attending meetings

☐ Talking on the telephone ☐ Movie theaters ☐ Attending worship

Do you have trouble hearing (CHECK ALL THAT APPLY)

☐ Telephone ring ☐ Doorbell ring ☐ Alarm clock

☐ Fire/smoke detector ☐ Siren ☐ Baby cry

List three areas where you have the most difficulty hearing or understanding:

1. _____

2. _____

3. _____

HEARING AID HISTORY

Have you ever used a hearing aid? ☐ Yes ☐ No

Do you use a hearing aid now? ☐ Yes ☐ No

If yes, how long have you been wearing hearing aids? _____

If yes, how long have you been wearing your current aids? _____

On which ear(s) do you use a hearing aid? ☐ Right ☐ Left ☐ Both

Do you wear it/them regularly? ☐ Yes ☐ No

Do you feel benefit from use? ☐ Yes ☐ No

List any problems you are having with the hearing aid(s):

_____

_____

FINISH UP

What would you improve with your current hearing aid(s)?

_____

_____

Is there any other information that we should know so that we can help you?

_____

_____

_____

CENTER FOR HEARING & SPEECH

Hearing Handicap Inventory for Adults

INSTRUCTIONS:

Answer ***No, Sometimes, or Yes*** for each question

1. Do not skip a question if you avoid a situation because of a hearing problem
2. If you use a hearing aid, please answer according to the way you hear with the aid

	No	Sometimes	Yes
1. Does a hearing problem cause you to feel embarrassed when you meet new people?	0	2	4
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	0	2	4
3. Do you have difficulty hearing/understanding co-workers, clients, or customers?	0	2	4
4. Do you feel handicapped by a hearing problem?	0	2	4
5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	0	2	4
6. Does a hearing problem cause you difficulty in the movies or in the theater?	0	2	4
7. Does a hearing problem cause you to have arguments with family members?	0	2	4
8. Does a hearing problem cause you difficulty when listening to TV or radio?	0	2	4
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	0	2	4
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	0	2	4
TOTALS			

Interpreting the Raw Score:

0-8= 13% probability of hearing impairment (no handicap)

10-24= 50% probability of hearing impairment (mild-moderate handicap)

26-40= 84% probability of hearing impairment (severe handicap)

Name: _____ Date: _____

*Adapted from: Ventry, I., Weinstein, B. "Identification of elderly people with hearing problems" American Speech-Language-Hearing Association. 1983, 25, 37-42.

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