Clarity Audiology
& Hearing Solutions, LLC

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ADULT CASE HISTORY

Name: ______________________ **Date:** ______________

1. Are you currently experiencing **hearing difficulties**?
   - ☐ Yes If so, for how long? ______________
   - ☐ No
2. Has your hearing **changed over time**?
   - ☐ Gradually declined ☐ Suddenly declined ☐ Fluctuates ☐ Improved ☐ No change
3. Do you feel like the hearing in one ear is significantly worse than the other?
   - ☐ Yes If so, which ear is **worse**? ______________
   - ☐ No
4. Have you ever worn **hearing aids**?
   - ☐ Yes If so, for how long? ______________
   - ☐ No If not, has anyone ever told you that you could benefit from hearing aids? ______________
5. Have you **recently** experienced any of the following?
   - ☐ Sudden change in hearing ☐ Ear pain ☐ Ear infection
   - ☐ Ear drainage ☐ Ear pressure/fullness ☐ Other: ______________
6. Have you recently **dizziness or vertigo** in the last 90 days?
   - ☐ Yes If so, please describe: ______________
   - ☐ No
7. Have you been exposed to **loud noises** (i.e. gunfire, occupational noise exposure, loud music) more so than average?
   - ☐ Yes If so, please describe: ______________
   - ☐ No
8. Do you **hear noises (i.e. ringing, buzzing, humming, or whooshing) in your ears** lasting longer than 2 minutes at a time?
   - ☐ Yes If so, please describe: ______________
   - ☐ No
9. Has anyone in your **family** experienced hearing loss?
   - ☐ Yes If so, who? ______________
   - ☐ No
10. Have you **ever** experienced any of the following?
    - ☐ Allergies ☐ Diabetes ☐ Sinus Problems ☐ Head injury ☐ High blood pressure
    - ☐ Stroke/TIA ☐ Cancer ☐ Ear surgery ☐ Heart Problems ☐ Neurological Problems
11. Are you currently taking any **prescription medications**?
    - ☐ Yes If so, what are you taking them for? ______________
    - ☐ No

Additional Comments: ______________