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**ADULT CASE HISTORY**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Are you currently experiencing **hearing difficulties**?
* Yes If so, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
1. Has your hearing **changed over time**?
* Fluctuates
* Suddenly declined
* No change
* Improved
* Gradually declined
1. Do you feel like the hearing in one ear is significantly worse than the other?
* Yes If so, which ear is **worse**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
1. Have you **recently** experienced any of the following?
* Ear infection
* Ear pain
* Sudden change in hearing
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Ear pressure/fullness
* Ear drainage
1. Have you experienced **dizziness or vertigo** in the last 90 days?
* Yes If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
1. 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
1. Do you **hear noises (i.e. ringing/ buzzing/humming/whooshing) in your ear(s** ) lasting longer than 2 minutes at a time?
* Yes If so, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If so, please indicate which ear(s): **right / left / both**

* No
1. Has anyone in your **family** experienced hearing loss?
* Yes If so, please list relation and approx.age of onset\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
1. Have you **ever** experienced any of the following?
* Vertigo/Dizziness
* High blood pressure
* Ear Surgery
* Sinus Problems
* Diabetes
* Allergies
* Heart Problems
* Head Injury
* Neurological Problems
* Cancer
* Thyroid Problems
* Stroke/TIA
* Dementia
* Alzheimer’s
* Memory Problems
* Anxiety/Depression
1. Are you currently taking a **blood thinning medication**?
* Yes
* No
1. Are you currently taking any other **prescription medications**?
* Yes If so, what are you taking them for?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
1. Do you use **tobacco products**?
* Yes
* No

**Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**