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 **recently** experienced any of the following?
   - ☐ Sudden change in hearing ☐ Ear pain ☐ Ear infection
   - ☐ Ear drainage ☐ Ear pressure/fullness ☐ Other: ____________
5. Have you experienced **dizziness or vertigo** in the last 90 days?
   - ☐ Yes If so, please describe: ______________________________
   - ☐ No
6. 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
7. 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
8. Has anyone in your **family** experienced hearing loss?
   - ☐ Yes If so, please list relation and approx.age of onset______________________________
   - ☐ No
9. Have you **ever** experienced any of the following?
   - ☐ Allergies ☐ Diabetes ☐ Sinus Problems ☐ Ear Surgery ☐ High blood pressure ☐ Vertigo/Dizziness
   - ☐ Stroke/TIA ☐ Cancer ☐ Thyroid Problems ☐ Heart Problems ☐ Neurological Problems ☐ Head Injury
   - ☐ Anxiety/Depression ☐ Memory Problems ☐ Alzheimer's ☐ Dementia
10. Are you currently taking a **blood thinning medication**?
    - ☐ Yes
    - ☐ No
11. Are you currently taking any other **prescription medications**?
    - ☐ Yes If so, what are you taking them for?______________________________
    - ☐ No
12. Do you use **tobacco products**?
    - ☐ Yes
    - ☐ No

Additional Comments: ______________________________