

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: **right / left / both**
constant / intermittent
bothersome / non-bothersome
 - 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