Clarity Audiology & Hearing Solutions, LLC

3290 North Ridge Road, Suite 125
Ellicott City, MD 21043
Phone: #410.696.2890 Fax: #410.696.2886

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. Have you ever had a cognitive screening/assessment?
    - ☐ Yes If yes, please describe:
    - ☐ No
11. Are you currently taking any other **prescription medications**?
    - ☐ Yes If so, what are you taking them for?_____
    - ☐ No

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AMPLIFICATION HISTORY (previous user)

Name: _____ **Date:** _____

1. How ***long have you been wearing*** hearing aids? _____
2. How ***old*** are your current hearing aids? _____
3. How ***often do you wear*** your current hearing aids? _____
4. What do you ***like*** about your current hearing aids? _____

   _____
5. What do you ***dislike*** about your current hearing aids? _____

   _____
6. How well do you hear in the following in the following listening situations WITH your hearing aids?

   a. One-on-one conversation

   (Not Well) 1 2 3 4 5 6 7 8 9 10 (Very Well)

   b. Hearing in small group settings

   (Not Well) 1 2 3 4 5 6 7 8 9 10 (Very Well)

   c. Hearing in noisy environments (i.e. restaurants)

   (Not Well) 1 2 3 4 5 6 7 8 9 10 (Very Well)

   d. Hearing the television

   (Not Well) 1 2 3 4 5 6 7 8 9 10 (Very Well)

   e. Hearing on your landline/cell phone

   (Not Well) 1 2 3 4 5 6 7 8 9 10 (Very Well)

   f. Hearing in a place of worship or auditorium (if applicable)

   (Not Well) 1 2 3 4 5 6 7 8 9 10 (Very Well)
7. What is your ***most important consideration*** regarding hearing aids?

   Rank 1-4 with 1 being the most important and 4 being the least important.

   ___ Performance

   ___ Ease of Use

   ___ Appearance

   ___ Cost