

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 Kidney Disease
10. Are you currently taking a blood-thinning medication?
 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

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