MONTCLAIR STATE UNIVERSITY

# Adult Case History Form – Audiology

## CONTACT INFORMATION

Name: _____ Date: _____

Address: _____

Date of Birth: _____ Telephone: _____ Cell: _____

Email: _____

Marital Status: _____ Occupation: _____

Primary Language: _____ Secondary Language: _____

## GENERAL INFORMATION

What brings you to the clinic? _____

Do you suspect you have a hearing loss? ☐ Yes ☐ No ☐ Not sure

If you suspect a hearing loss, how long have you noticed the problem? _____

With which ear do you hear the best? ☐ Right ear ☐ Left ear ☐ Both same

What do you feel is the cause of your hearing loss? _____

Describe the progression of your hearing loss. ☐ Fluctuating ☐ Rapidly changing ☐ Gradually changing ☐ Sudden loss

Have you ever been exposed to occupational (military service, factory) or recreational noise (hobbies)? ☐ Yes ☐ No

If yes, please describe: _____

Does anyone in your family have a hearing loss? ☐ Yes ☐ No ☐ Not sure

If yes, please describe: _____

Have you had your hearing tested? ☐ Yes ☐ No

If yes, please describe: _____

What were the results? _____

Have you seen a physician for your hearing? ☐ Yes ☐ No

If yes, when and where? _____

**MEDICAL HISTORY**

Have you had earaches or drainage from your ears within the last 3 months? ☐Yes ☐No

Have you ever experienced dizziness, balance problems, or falls? ☐Yes ☐No

Are you feeling dizzy today? ☐Yes ☐No

If yes, select other experiences you also have? (select all that apply)

☐ Nothing else ☐ Ringing in your ears ☐ Changes in vision
☐ Nausea ☐ Hearing loss ☐ Other

Please describe the feeling. _____

How often does it happen? _____

Have you fallen in the last 12 months? ☐Yes ☐No

If yes, how many times did you fall? _____

If yes, were you injured? ☐Yes ☐No

Please describe the injury. _____

Do you experience visual difficulties of experiences? ☐ Yes ☐ No ☐ Sometimes

If yes, please describe _____

Do you currently take a vitamin D supplement? ☐Yes ☐No

Have you ever had a feeling of fullness or stuffiness in your ears? ☐Yes ☐No

If yes, which ear? ☐Right ear ☐Left ear ☐Both ears

How often do you feel it? _____

Please describe the feeling. _____

Have you ever had any tinnitus (ringing, buzzing or roaring) in your ears? ☐Yes ☐No

If yes, which ear? ☐Right ear ☐ Left ear ☐ Both How frequently? _____

Is it bothersome? ☐Yes ☐ No ☐Sometimes

Please describe the sounds _____

Do you experience facial weakness, numbness or tingling? ☐Yes ☐ No ☐Sometimes

If yes, please describe? _____

**MEDICAL HISTORY**

Have you ever had medical/surgical treatment for your head, neck, ears, or throat? ☐Yes ☐No

If yes, please describe: _____

Have you ever experienced head trauma? ☐Yes ☐No

If yes, please describe: _____

Are you receiving or have you ever received any of the following (Select all that apply)? ☐ Yes ☐ No

- ☐ Speech/Language Therapy (Communication)
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Other

If yes, please describe: _____

List any medications you are taking or have taken recently.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Do you have any open sores or are you bleeding now? ☐Yes ☐ No

Have you had any of the following? (Check all that apply)

| | | |
|---|---|---|
| ☐ Arthritis | ☐Diabetes – Type II | ☐ Multiple Sclerosis |
| ☐ Allergies | ☐Hepatitis | ☐ Pacemaker |
| ☐ Bell's Palsy | ☐High Blood Pressure | ☐ Parkinson's Disease |
| ☐ Cancer | ☐High Fevers | ☐ Scarlet Fever |
| ☐ Concussion/Skull Fracture | ☐HIV | ☐ Seizures |
| ☐ Dementia/Alzheimer's | ☐Measles | ☐ Stroke/TIA |
| ☐ Depression/Anxiety | ☐Meningitis | ☐ Tuberculosis |
| ☐ Diabetes – Type I | ☐Mumps | ☐ Vision Problems |

**HEARING HISTORY**

Do you have difficulty hearing/understanding during any of the following activities?
(CHECK ALL THAT APPLY)

☐ Watching TV ☐ Dining in restaurants ☐ Attending meetings

☐ Talking on the telephone ☐ Watching movies in the theater ☐ Attending worship services

Do you trouble hearing (CHECK ALL THAT APPLY)

☐ Telephone ring ☐ Doorbell ring ☐ Alarm clock

☐ Fire/smoke detector ☐ Siren ☐ Baby cry

List three areas where you have the most difficulty hearing or understanding:

1. _____

2. _____

3. _____

Which ear do you use when talking on the telephone? ☐ Right ☐ Left ☐ Switch between ears

Are you right or left handed? ☐ Right ☐ Left

**SOCIAL HISTORY**

Have you used a tobacco product (cigarette, cigar, pipe, smokeless tobacco in the last 24 months? ☐ Yes ☐ No

If yes, how often have you used it in the last 24 months? _____

If yes, which products have you used? _____

Are you currently being treated for an emotional illness, behavioral illness, depression or substance abuse? ☐ Yes ☐ No

Have you had any recent changes in your functioning or behavior (including acting out, irritability, fights at home/work/school)? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No

Have you felt down, depressed or hopeless in the past few months? ☐ Yes ☐ No

## HEARING AID HISTORY

Have you ever used a hearing aid? ☐Yes ☐No

Do you use a hearing aid now? ☐Yes ☐No

If yes, how long have you been wearing hearing aids? _____

If yes, how long have you been wearing your current aids? _____

On which ear(s) do you use a hearing aid? ☐Right ear ☐Left ear ☐Both

Do you wear it/them regularly? ☐Yes ☐No

Do you feel benefit from use? ☐Yes ☐No

List any problems you are having with the hearing aid(s):

_____

_____

What would you improve with your current hearing aid(s)?

_____

_____

## FINSIH UP

Is there any other information that we should know so that we can help you?

_____

_____

_____

_____

_____

_____

Who can we thank for referring you to CASLP? _____

Name of the person completing this form: _____

Relation to the client? _____

Signature _____ Date: _____