sonus hearing care professionals

Adult Case History Form

Patient Name ______________________ **Age** ________ **Date** ____________

1. Chief complaint(s):
   - ☐ Decreased Hearing or Understanding (Right/Left/Both)
   - ☐ Fullness/Pressure in Ear (Right/Left/Both)
   - ☐ Diziness/Vertigo
   - ☐ Tinnitus (Ringing or Buzzing) (Right/Left/Both) (Steady or Pulsing)
   - ☐ Sudden Change in Hearing (Right/Left/Both)
   - ☐ Pain/Discomfort in Ear (Right/Left/Both)
   - ☐ Drainage/Discharge from Ear (Right/Left/Both)

2. How long have you noticed this difficulty? __________ Days Gradual

3. Is one ear better than the other? Neither

4. Is this problem due to a work-related injury/exposure? No
   If yes, please explain and give date of injury:
   ____
   ____

5. Have you ever been exposed to loud noise? No
   If yes, please check all that apply:

   ☐ Farm Machinery ☐ Music ☐ Firearms ☐ Factory Noise
   ☐ Power tools ☐ Military ☐ Jet engines Other:________________

6. Do your ears produce a buildup of wax? No

7. Have you seen a physician about your ears/hearing? No
   If yes, when and where? ______________________________

8. Have you ever had a **hearing test** before? No
   If yes, how long ago and what were the results?______________________

9. Have you had **surgery, chemotherapy,** or **radiation** that affected your hearing or balance? No
   If yes, what type and when? ______________________________

10. Is there a history of hearing loss in your family? No
    If yes whom? ______________________________

11. Do you wear a pacemaker? No

12. Do you wear hearing aids? No Both Ears
    If yes how long? ____________How would you rate them on a scale of 1-10? __________

13. Who referred you to us today:______________________________

Please check (√) if you have experienced any of the following:

- ○ Tubes in eardrum
- ○ Ear drainage/bleeding
- ○ Swimmer's Ear
- ○ Ear Surgery
- ○ Popping sensation in the ear
- ○ Sensitivity to loud noises
- ○ Fluid behind the eardrum
- ○ Fluctuating/sudden hearing loss
- ○ Abnormal ear structure
- ○ Dizziness/Vertigo
- ○ Ear infection within last year
- ○ Wax removal

Describe:____

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Please check (√) if you have been diagnosed with any of the following:

- ○ Otosclerosis
- ○ Cholesteatoma
- ○ Bell's palsy
- ○ Labyrinthitis
- ○ Meniere's disease
- ○ Barotrauma
- ○ Permanent hearing loss
- ○ Ossicular dislocation/fixation
- ○ Acoustic neuroma

Describe:____

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Please check (√) if you have experienced any of the following:

- ○ Heart disease
- ○ Mumps
- ○ Kidney or renal problems
- ○ Stroke/TIA
- ○ Meningitis
- ○ Chronic sinus infections
- ○ Diabetes
- ● Measles
- ○ Environmental allergies
- ○ High blood pressure
- ○ Scarlet fever
- ○ Cancer
- ○ Hypothyroidism
- ○ HIV/AIDS
- ○ Radiation/chemotherapy
- ○ Asthma
- ○ Tuberculosis
- ○ Long term IV antibiotics
- ○ Mental illness
- ○ Head trauma
- ○ Depression or anxiety
- ○ Hepatitis A, B or C
- ○ Loss of Consciousness
- ○ Migraines
- ○ Liver Problems
- ○ Exposure to chemicals/solvents

14. Please indicate if you currently take medications for any of the following:

- ☐ Blood pressure
- ☐ Diuretics (fluid pills)
- ☐ Asprin
- ☐ Blood thinners
- ☐ Cholesterol

15. Please list your current prescriptions/reason for taking:

- ____
- ____
- ____
- ____
- ____
- ____