WARRIOR HEARING CENTER

ADULT CASE HISTORY - AUDIOLOGY

PLEASE PRINT Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ Gender: _____ Male Female (please circle)

Street Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____ Place of Employment: _____

How would you prefer to be contacted: (please check one)

☐ Home Phone ☐ Work Phone ☐ US Mail ☐ Email

Family Physician: _____ Referred by: _____

Please check the appropriate answer. Fill in blanks where indicated.

YES	NO	
☐	☐	Do you feel you have difficulty hearing? If so, which ear? ☐ Right ☐ Left ☐ Both For how long? _____ Is the problem becoming worse? ☐ Yes ☐ No
☐	☐	Do you have trouble understanding people when they talk?
☐	☐	Have you recently experienced pain or drainage in your ears?
☐	☐	Have you ever had bleeding from your ears? If so, which ear? ☐ Right ☐ Left ☐ Both
☐	☐	Do you have noises in your ears? Which ear? ☐ Right ☐ Left ☐ Both What does it sound like? ☐ ringing ☐ clicking ☐ buzzing ☐ other _____
☐	☐	Do your ears feel plugged? If so, which ear ☐ Right ☐ Left ☐ Both
☐	☐	Do you have dizzy spells? If so, when was the last one? Please describe: _____
☐	☐	Have you ever had an operation on your ears? If so, which ear? ☐ Right ☐ Left ☐ Both What type of surgery? _____
☐	☐	Have you ever had a doctor remove wax from your ears? If so, how long ago? _____ Which ear? ☐ Right ☐ Left ☐ Both
☐	☐	Is there a family history of hearing loss, such as in your parents, brothers or sisters? If so, what type and whom? _____
☐	☐	Have you ever worked around loud noises? If so, did you wear ear protection? _____ How long have you worked around loud noise? _____ What type of loud noise? ☐ factory work ☐ construction ☐ farm machinery ☐ motorcycles ☐ loud engines ☐ power tools ☐ loud music ☐ lawn mowers ☐ military artillery

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816-592-3575 ▲ warriorhearing.com

Please check the appropriate answer. Fill in blanks where indicated.

YES NO

☐ ☐ Do you have any noisy hobbies?

If so, do you wear ear protection? _____

What type of loud noise? ☐ snowmobiles ☐ motorcycles ☐ dirt bikes ☐ carpentry ☐ power tools ☐ loud engines ☐ loud music ☐ gunfire ☐ jet skis

☐ ☐ Have you ever worn a hearing aid? For which ear? ☐ Right ☐ Left ☐ Both

If so, when did you obtain it/them? _____

What concerns do you have about your hearing aids? _____

☐ ☐ Do you have any difficulties with your sense of touch or handling small objects?

☐ ☐ Do you have any serious vision problems? If so, what type? _____

☐ ☐ Do you use tobacco products?

Please indicate whether you have had any of the following health problems:
(Please check all that apply)

☐ Allergies
☐ Sinusitis
☐ Meningitis
☐ Scarlet Fever or Prolonged Low Fever
☐ Prolonged High Fever
☐ Mumps
☐ Measles
☐ Tuberculosis (TB)
☐ Cytomegalovirus (CMV)
☐ Syphilis
☐ Hepatitis (A, B or C)
☐ Diabetes
☐ Heart Disease or High Blood Pressure
☐ Hypothyroidism
☐ Kidney Disease
☐ Frequent Ear Infections
☐ Arthritis
☐ Tremors (e.g.: Parkinson's Disease)
☐ Multiple Sclerosis
☐ Cerebral Palsy
☐ Traumatic Brain Injury/Head Trauma
☐ Stroke, Brain Attack, TIA or CVA
☐ Alzheimer's Disease or Dementia
☐ Concussion or Loss of Consciousness
☐ Seizure Disorder
☐ Other Neurological Disease:
☐ Frequent Severe Headaches or Migraine
☐ Developmental Disability
☐ Temporomandibular Joint Disorder (TMJ)
☐ Cleft Palate
☐ Immune Deficiency Disorder
☐ Cancer - What type? _____
☐ Other Disease of the Ear: _____

What medications are you currently taking? _____

_____

_____

Which of the following types of medications have you taken?

☐ Diuretics
☐ Antibiotics
☐ Blood Pressure/Heart Medication
☐ Antimalarial Medication
☐ Anti-inflammatory or Arthritis Medication
☐ Chemotherapy
☐ Cholesterol Lowering Medication
☐ Immunosuppressant, e.g.: Transplant Medication