Hearing Healthcare of Havasu

Adult Case History Form

Please fill in as much information as accurately as possible. The confidential information you provide will assist in formulating a complete profile and formulate your intervention plan.

Patient Name _____ Date of Birth _____ Date _____

Hearing/Ear History

Reason for today's visit _____

What are your goals for today's visit or for your future long-term hearing health? _____

_____

Last hearing exam - Date _____ Clinic/Provider Name _____

Do you have difficulty hearing? ▢Yes ▢No How long have you noticed a decline? _____

Have you experienced a sudden or progressive hearing loss within the last 90 days? ▢Yes ▢No

Which ear appears to have better hearing? ▢Right ▢Left ▢No Difference

Do you currently have ear pain or discomfort? ▢Yes ▢No ▢Right ▢Left ▢Both

Do you experience tinnitus (ringing, humming, buzzing)? ▢Yes ▢No ▢Right ▢Left ▢Both

Do you experience acute or chronic dizziness/imbalance? ▢Yes ▢No

Do you have a history of significant noise exposure (firearms, power tools)? ▢Yes ▢No _____

Do you have a family history of hearing loss? ▢Yes ▢No

Do you have a history of ear surgery? ▢Yes ▢No Surgery type _____

Do you have a history of chronic ear infections? ▢Yes ▢No

Have you experienced any drainage from your ear(s) within the last 90 days? ▢Yes ▢No

Have you ever used assistive listening devices? ▢Yes ▢No Currently? ▢Yes ▢No

Hearing Technology - Which ear do you wear hearing devices in? ▢Right ▢Left ▢Both ▢Neither

If you have hearing technology, how long have you been using the devices? _____

Are you satisfied with your current hearing technology? ▢Yes ▢No Why?_____

What are some situations that you wish you could hear better in? _____

Medical History

Do you have any chronic conditions, including any of the following? _____

▢Arthritis	▢Cognitive Decline	▢High Blood Pressure	▢Other
▢Bell's Palsy	▢Diabetes	▢Measles/Mumps	_____
▢Cancer	▢Heart Problems	▢Meningitis	_____