

# Adult Case History

NAME: \_\_\_\_\_

D.O.B. \_\_\_\_\_

**YES**      **NO**

- Do you have any problems hearing? If yes, for how long? \_\_\_\_\_  
Which ear?    Right    Left    Both ears
- Do your friends/family complain about your hearing?
- Do you have ringing or other sounds in your ears? If yes, which ear?  
                     Right    Left    Both ears  
How often?     Constantly    Intermittently    Unsure
- Have you had dizziness?
- Have you had ear surgery, ear infections, ear pain, skull fracture/concussion?  
(Circle all that apply)
- Have you ever been exposed to loud noises on a regular basis?  
If yes, what kind of noise and for how long? \_\_\_\_\_
- Does anyone in your family have a hearing loss? If yes, which family  
member(s) and how old were they when their loss began? \_\_\_\_\_  
\_\_\_\_\_
- Have you ever had a hearing test? If yes, please give the year and location  
of your last test. \_\_\_\_\_
- Have you ever worn a hearing aid? If yes, which ear?  
                     Right    Left    Both      For how long? \_\_\_\_\_
- Are you interested in trying hearing aids?
- Do you regularly take medications?  
If yes, for what condition(s)? \_\_\_\_\_

Look below and check any conditions that apply

- Meningitis       Cardiac problems       High blood pressure       Diabetes
- Scarlet fever       Other \_\_\_\_\_

