DELAWARE SPEECH & HEARING CENTER
AUDIOLOGY CASE HISTORY – ADULT (R) 10/2018

APPT DATE: _____TIME:_____ **Please call 740-369-3650 to cancel/ reschedule.**

☐ 494 W Central Ave., Delaware ☐ 3940 N Hampton Dr., Powell

PLEASE BRING COMPLETED FORMS, INSURANCE CARD(S), PHOTO ID, & MEDICATION LIST

How did you hear about us (Whom can we thank)? _____

Patient's Name: _____ Birthdate: _____ Age:_____

Address:_____ Male ☐ Female ☐

City: _____ Zip: _____ County: _____

Phone: Home _____ Work _____ Cell _____

Home - Ok to leave message ☐ Work - Ok to leave message ☐ Cell - Ok to leave message ☐

Would you like to receive our newsletter? Yes Electronic ☐ Mail ☐

Email: _____

Employer: _____ Spouse's Name: _____

Emergency contact name and phone number: _____

NEW PATIENTS: FILL OUT QUESTIONS BELOW. CURRENT PATIENTS: REVIEW BELOW AND NOTE ANY CHANGES

What brings you in today?_____
What would you like to learn from your visit? _____

Hearing/Ear History

Please complete the following:

1.) Hearing Loss — When did you notice hearing loss:_____
2.) Tinnitus/ringing — Describe: _____
3.) Ear Surgery — Details (tubes, etc.):_____
4.) Dizziness — Describe: _____
5.) Noise exposure — Describe (hunting, factory, etc.):_____
6.) Hearing loss in family — List relatives with hearing loss:_____
7.) Ear Pain
8.) Ear Drainage

Hearing Aid History

Have you ever worn hearing aids? For how long? _____
Do you currently wear aids?
How old are your current aids?
Are you happy with your aids? Explain: _____

Other Health History

Please check all that apply:

☐ High Cholesterol ☐ Seizures ☐ Stroke/TIA ☐ Pace-maker
☐ High Blood Pressure ☐ Diabetes ☐ Atrial Fib ☐ Tobacco use
☐ Memory loss/dementia ☐ Cancer*

*Please list type of cancer treatment _____
Any other significant medical history? _____
List all medications/supplements, including dosage instructions: