DELAWARE SPEECH & HEARING CENTER

AUDIOLOGY CASE HISTORY – ADULT (R) 01/2016

YOUR APPOINTMENT IS

	Grady Memorial Hospital	494 W Central Ave; Delaware
_____ AT _____	561 W Central Ave; Delaware	3940 N Hampton Dr; Powell

Please call 740-369-3650 if you need to cancel or reschedule your appointment

PLEASE COMPLETE ALL OF THE ENCLOSED FORMS & BRING THEM TO YOUR APPT ALONG WITH <u>INSURANCE CARD(S), PHOTO IDENTIFICATION, AND LIST OF MEDICATIONS</u> Including Dosage Instructions.

How did you hear about us? _____

Who can we thank for referring you? _____ **Address** _____

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

Address: _____ Male Female

City: _____ Zip: _____ County: _____

(H) Phone: _____ (W) Phone _____ (Cell) _____

(H) Ok to leave message (W) Ok to leave message (Cell) Ok to leave message

Email: _____ Would you like to receive our newsletter Y N Electronic Mail

Employer: _____ Spouse's Name _____

What concerns you most?

___ Hearing Loss ___ Dizziness ___Ear Noises (tinnitus) ___Ear Pain __ Other (Specify) _____

What do you want to learn from your visit today? _____

_____

1. If you think you have a hearing problem, please answer the following. If not go to #2.
   a. When did you first notice your hearing loss? _____
   b. What do you think caused your hearing loss? _____
   c. Does anyone in your family have a hearing problem/and wear hearing aids? _____ Yes _____ No If "Yes", Who: _____
   d. From which ear do you hear better? _____ Left _____ Right _____ Same
   e. Did your hearing loss come on _____ Suddenly _____ Gradually
   f. Has it gotten worse over time? _____ Yes _____ No
   g. Does it fluctuate from time to time? _____ Yes _____ No
2. Have you ever had ear surgery? _____ Yes _____No _____ Ear Tubes?
   If you have had "tubes", are they in place now? _____ Yes _____ No _____ Don't Know
3. Do you notice sound/noises in your ears/head? _____ Yes _____ No __ Left __ Right __Both
   If yes, describe sound_____
4. Are you ever dizzy/have problems with balance _____ Yes _____ No
   If "Yes", describe _____
5. Have you <u>ever</u> been exposed to loud noises for any length of time? _____ Yes _____No
   If "Yes", how long? _____
6. Have you ever used a hearing aid in the past? _____Yes (for how long? _____) _____ No
7. If you are using a hearing aid now, please answer the following: otherwise, go to #8.
   a. Which ear is aided? _____Left _____ Right _____ Both
   b. How long have you used an aid? _____
   c. How long have you had your present aid? _____
   d. Are you satisfied with the aid? _____ Yes _____ No

8. Do you use tobacco products? _____ Yes _____ No

9. Do you have a history of any of the following?

a. Stroke	_____ Yes	_____ No	b. High Blood Pressure	_____ Yes	_____ No
c. Heart Problems **	_____ Yes	_____ No	d. High Cholesterol	_____ Yes	_____ No
e. Seizures	_____ Yes	_____ No	f. Diabetes	_____ Yes	_____ No
g. Cancer ***	_____ Yes	_____ No	h. Memory/Dementia	_____ Yes	_____ No

** If yes, do have a pacer maker? _____ If "Yes", how was the cancer treated? _____

Any other significant medical history? _____