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 None
2.) Tinnitus/ringing None
3.) Ear Surgery None
4.) Dizziness No
5.) Noise exposure No
6.) Hearing loss in family No
7.) Ear Pain None
8.) Ear Drainage None

When did you notice hearing loss:_____
Describe: _____
Details (tubes, etc.):_____
Describe: _____
Describe (hunting, factory, etc.):_____
List relatives with hearing loss:_____

Hearing Aid History

Have you ever worn hearing aids? No None For how long? _____
Do you currently wear aids? No None
How old are your current aids?
Are you happy with your aids? None 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: