PHILIP AUDIOLOGY
& HEARING AID SERVICES
Professional Mobile Hearing Care You can Trust

ADULT CASE HISTORY

Name: ____

Date: ____________________

HEARING:
Are you having any type of hearing difficulties?
____

Previous hearing tests: Y N **Date of last evaluation:**
Results: ____

Family History of Hearing Loss: Y N **Relationship:** ____________________

Noise exposure (recreational or occupational:
____

Military Experience: ____

Tinnitus (ringing in the ears): R L Both
Describe: (type, severity, fluctuation, onset, frequency, duration)
____

Have you worn hearing aids before? ____

Sensitivity to loud sounds: Y N
Describe: ____
Fullness feeling in ear: R L Both
Discharge/pain in ear: R L Both
Dizziness: Y N
Describe: (type, frequency, onset, nausea, vertigo, duration)

____
____

MEDICAL HISTORY:

Middle and external ear problems: Y N (please explain)

____

Otological treatment/Ear Surgeries: Y N (please explain)

____

Associated/Serious Illnesses and/or if medications used :

- **Ear Infections** ____________________
- **Headaches** ____________________
- **Sinus problems** ____________________
- **Sleep Disorder** ____________________
- **Blood Pressure** ____________________
- **Respiratory System** ____________________
- **Cancer** ____________________
- **Diabetes** ____________________
- **Depression/Anxiety** ____________________
- **Reproductive System** ____________________
- **Digestive System** ____________________
- **Neurologic** ____________________
- **Urinary/Kidney** ____________________
- **Bone/Joint** ____________________

Dexterity problems: ____________________

Cell phone user: ____________________

Head Trauma/ Head Injuries: Y N (please explain)

____

____

Current health status/problems/treatments:

____

____

Current Medications: list name of medication, dose, frequency, and route or means of taking the medication):

____

____

Who did you bring with you to your appointment today?

____

Relationship: ____________________