WELCH-SCHMIDT CENTER FOR COMMUNICATION DISORDERS
MARTIN 34
WARRENSBURG, MISSOURI 64093
660-543-4993

ADULT CASE HISTORY - HEARING

Before an assessment is scheduled we would appreciate you answering the following questions as accurately and completely as possible. When the form is completed, please mail it in the enclosed postage paid return envelope. You will be contacted for an assessment appointment when we receive the completed case history form. All information is for the confidential use of our clinic staff.

Date_____

Name:_____ **Phone**: (_____)_____-_____ (H)
(Last) (First) (M.I.)

Address_____ **Phone**: (_____)_____-_____ (C/W)

City_____**St**._____**Zip**_____

e-mail address: _____

Date of birth: _____/_____/_____ **Age**: _____ **Sex**: [ ] M [ ] F

Occupation: _____ **Spouses Name**:_____

Who referred you?_____

Purpose of visit _____

PATIENT EVALUATION OF HEARING DIFFICULTY

Do you think you have difficulty hearing? [ ]Yes [ ]No
If yes, how long have you had problems and has it changed since the onset? (better or worse)

_____

_____

Does anyone in your family have a hearing impairment? [ ]Yes [ ]NO If so, what is their relation to you and describe the loss _____

_____

What do you think caused your hearing loss? _____

Do you notice any fluctuations in your hearing? [ ]Yes [ ]No If so, explain _____

_____

Do you often hear better in noise than in quiet? [ ]Yes [ ]No
In what situation(s) do you have difficulty hearing? [ ]Noise [ ]Quiet [ ]Group [ ]Telephone [ ]Distance [ ]Television [ ]Other(Explain)_____

_____

Do you have difficulty determining from which direction a sound comes? [ ]Yes [ ]No Explain _____

_____

Does your occupation or any hobbies expose you to high levels of noise for long periods of time? (factory, heavy equipment, gunfire, etc.) [ ]Yes [ ]No If yes, explain_____

_____

MEDICAL HISTORY

Have you seen a doctor or an audiologist about your hearing problem? [ ]Yes [ ]No If so, were there any recommendations?_____

Other than a screening, have you ever had your hearing tested before? [ ]Yes [ ]No

Professional's Name and address: _____

_____

Do you have a history of ear drainage or ear pain? [ ]Yes [ ]No If so, explain _____

_____

Have you ever had any ear infections? [ ]Yes [ ] No Explain_____

_____

Do you experience any of the following frequently? [ ]Allergies [ ]Asthma [ ]Headaches [ ]Head colds [ ]Seizures

Do you experience ringing in your ears? [ ]Yes [ ]No If so how often and how distracting_____

_____

Describe the sound (buzz, roar, etc.)_____

Do you ever experience dizziness? [ ]Yes [ ]No If so, describe sensation and how long it lasts and any associated occurrences (ringing in ears, nausea, etc.)_____

_____

_____

Are you currently taking any medications? [ ]Yes [ ]No If yes, please list_____

_____

Have you ever had any surgery that may have had an effect on your hearing problem? [ ]Yes [ ] No

Explain _____

Have you ever had any serious head injury? [ ]Yes [ ]No When _____

Were you unconscious? [ ]Yes [ ]No

How would you describe your general health?_____

_____

HEARING AIDS

Do you wear a hearing aid? [ ]Yes [ ]No

If yes, [ ] Right [ ] Left Make: _____ Model: _____

How long have they been worn? _____Do they seem to help? [ ]Yes [ ]No

Are you satisfied with it? [ ]Yes [ ]No If not, explain_____

_____

Please add any information which you feel might be useful/helpful _____

_____