BETTERLIVING AUDIOLOGY

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Patient Case History Form

Patient Name: _____ Date of Completion: _____

Completed by (if pediatric/minor patient): _____

Have you experienced any of the following major medical conditions (please check all that apply):

- ☐AIDS/HIV
- ☐Arthritis
- ☐Blood Disorders
- ☐Cancer
- ☐Chicken Pox
- ☐Depression
- ☐Diabetes
- ☐Diphtheria
- ☐Encephalitis
- ☐Fatigue
- ☐Genetic Disorders
- ☐Headaches
- ☐Head Injury
- ☐Heart Problems
- ☐High Blood Pressure
- ☐High Fevers
- ☐Influenza
- ☐Malaise
- ☐Malaria
- ☐Measles
- ☐Meningitis
- ☐Mumps
- ☐Scarlet Fever
- ☐Stroke
- ☐TMJ
- ☐Typhoid
- ☐Vascular Problems
- ☐Other: _____

Please check all medical symptoms or conditions that apply:

- ☐Eye problems (such as blurred or double vision, pain)
- ☐Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues)
- ☐Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations)
- ☐Respiratory issues (such as shortness of breath, cough, wheezing)
- ☐Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain)
- ☐Musculoskeletal issues (such as joint pain, swelling, recent trauma)
- ☐Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness)
- ☐Psychiatric issues (such as depression, anxiety, compulsions)
- ☐Endocrine symptoms (such as frequent urination, hot flashes)
- ☐Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands)
- ☐Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency)

Comments related to Review of Symptoms above:

Do you currently use recreational drugs? ☐Yes ☐No

If yes, what drugs: _____

How often: ☐Daily ☐Weekly ☐Monthly ☐Occasionally ☐Rarely

Do you currently use any tobacco products? ☐Yes ☐No

If yes, what do you use: ☐Cigarettes ☐Cigars ☐Pipe ☐Smokeless ☐Other: _____

If yes, amount of use per day: _____

Do you currently drink alcoholic beverages? ☐Yes ☐No

If yes, how often: ☐Daily ☐Weekly ☐Monthly ☐Occasionally ☐Rarely

Current Medications:

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Allergies (foods, medications, plastics, etc.): _____

_____

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence: _____

_____

Audiologic History

Do you experience hearing loss? ☐Yes ☐No

If so, which ear? ☐Right ☐Left ☐Both

If you experience hearing loss, which best describes it? ☐Gradual ☐Fluctuating ☐Sudden

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Have you ever had a hearing test? ☐Yes ☐No

If so, when: _____

Which ear do you typically use to talk on the telephone: ☐Right ☐Left

Have you ever worn or tried a hearing aid or amplifier? ☐Right ear ☐Left ear ☐Both ears

What type and/or style of hearing aid or amplifier: _____

Please describe your experience: _____

Please check all of the medical conditions that apply:

☐**Developmental disorder/delay**
If checked, please explain: _____

☐**Dizziness or unsteadiness**
If checked, is it accompanied by: ☐Vomiting ☐Nausea ☐Ear Noises

☐**Ear deformity**
If checked: ☐Right ear ☐Left ear ☐Both ears

☐**Ear drainage**
If checked: ☐Right ear ☐Left ear ☐Both ears

☐**Ear pain**
If checked: ☐Right ear ☐Left ear ☐Both ears

☐**Family history of hearing loss**
If checked, who is the family member: _____

☐**History of ear infections**
If checked: ☐Right ear ☐Left ear ☐Both ears

☐**History of earwax buildup**

☐**History of noise exposure**
If checked, please describe: _____

☐**Previous ear surgery**
If checked: ☐Right ear ☐Left ear ☐Both ears
If so, when: _____

☐**Tinnitus/ringing/noises in ears**
If checked: ☐Right ear ☐Left ear ☐Both ears
If so, frequency: _____

☐**Other (please describe): _____**

Hearing Handicap Screening (please select the most appropriate response):

- **Does a hearing problem cause you to feel embarrassed when meeting new people?**

  ☐Yes ☐No ☐Sometimes

- **Does a hearing problem cause you to feel frustrated when talking to members of your family?**

  ☐Yes ☐No ☐Sometimes

- **Do you have difficulty hearing when someone speaks in a whisper?**

  ☐Yes ☐No ☐Sometimes

- **Do you feel handicapped by a hearing problem?**

  ☐Yes ☐No ☐Sometimes

- **Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?**

  ☐Yes ☐No ☐Sometimes

- **Does a hearing problem cause you to attend lectures or religious services less often than you would like?**

  ☐Yes ☐No ☐Sometimes

- **Does a hearing problem cause you to have arguments with family members?**

  ☐Yes ☐No ☐Sometimes

- **Does a hearing problem cause you difficulty when listening to TV or radio?**

  ☐Yes ☐No ☐Sometimes

- **Do you feel that any difficulty with your hearing limits or hampers your personal or social life?**

  ☐Yes ☐No ☐Sometimes

- **Does a hearing problem cause you difficulty when in a restaurant with relatives and friends?**

  ☐Yes ☐No ☐Sometimes