Clarity Hearing
TINNITUS, BALANCE & PROCESSING

Adult Case History Form

Patient Name: _____ Date of Birth:_____

Reason for today's visit: _____

Medical History

Current Medications:

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

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

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

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Genetic Disorders
- ☐ Headaches
- ☐ Head Injury
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Fevers
- ☐ Meningitis
- ☐ Stroke
- ☐ TMJ
- ☐ Other: _____

Please check all medical symptoms or conditions that apply:

- Eye problems (such as blurred or double vision, pain): ☐ Yes ☐ No
- Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues): ☐ Yes ☐ No
- Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations): ☐ Yes ☐ No
- Respiratory issues (such as shortness of breath, cough, wheezing): ☐ Yes ☐ No
- Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain): ☐ Yes ☐ No
- Musculoskeletal issues (such as joint pain, swelling, recent trauma): ☐ Yes ☐ No
- Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness): ☐ Yes ☐ No
- Psychiatric issues (such as depression, anxiety, compulsions): ☐ Yes ☐ No
- Endocrine symptoms (such as frequent urination, hot flashes): ☐ Yes ☐ No
- Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands): ☐ Yes ☐ No
- Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency): ☐ Yes ☐ No

Clarity Hearing
TINNITUS, BALANCE & PROCESSING

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 experienced dizziness, unsteadiness, imbalance or vertigo? Yes No

If yes, are you feeling dizzy today? ☐ Yes ☐ No

If yes, please describe: _____

Frequency of occurrence: _____

If yes, is it accompanied by nausea ringing or noises in your ear hearing loss visual disturbances

Have you fallen within the past 12 months? ☐ **Yes** ☐ **No**

If yes, how many falls have you experienced in the 12 months? _____

If you have fallen, have you been injured? ☐ Yes ☐ No

Please describe your injury: _____

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: _____

☐ 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): _____

Clarity Hearing
TINNITUS, BALANCE & PROCESSING

Audiologic History

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