

Ears of Ardmore, Inc.

1505 N Commerce Ste 111

Ardmore, Ok 73401

Case History- Adults

(Please Print)

Date _____

Client's Name _____
Last First MI

Birthdate: ___/___/___ Age: ___ Gender: Female Male

Description of Hearing Loss

What information would you like from us regarding your hearing?

Please list the situations in which you have trouble hearing.

When did you first notice a problem with your hearing? ___ Years ago ___ Months

Do you feel that the onset of hearing loss was: ___ Sudden ___ Gradual

Do you feel you hear better in one ear? ___ Yes, right ___ Yes, left ___ ears same

Do you experience any noises (ex- ringing, buzzing) in your ears:

___ right ___ left ___ both ears ___ No

Do you experience any dizziness, light headedness, or balance problems? ___ Yes ___ No

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

If yes, when and by whom? _____

Results: _____

Family History

Please check any relatives who developed hearing loss prior to age 30:

___ Mother ___ Father ___ Grandfather ___ Grandmother

___ Brother(s) ___ Sister(s) ___ Aunt(s) ___ Uncle(s)

___ Cousins ___ Nephew(s) ___ Niece(s) ___ Other

Medical History

Please check if you have ever had or are currently experiencing any of the following medical condition(s):

- kidney problems liver problems diabetes
- arthritis sinus problems hypertension (high blood pressure)
- heart condition allergies

Other: _____

Please list medications (prescription and over-the-counter) you are currently taking:

Ear History

Please check all of the following which apply to you:

- Head/Neck injuries (e.g., head trauma or other serious injury)
- Ear pain Ear surgery Ear drainage Ear infections

If you checked any of the above, please explain:

Noise Exposure

Please check all of the following which apply to you:

- Military Service Carpentry/Construction Hunting/firearms
- Factory Noise Farming Equipment Music Other

Did/do you use protection when exposed to excessive noise? Yes No

Hearing Aids

Do you currently wear hearing aid(s)? Right Left Both No

If so, when did you begin wearing them? _____

How old is/are your current hearing aid(s)? _____

How often do you wear it/them? _____

Do you feel you are benefiting from the use of your hearing aid(s)? Yes No

Signature of Person Completing Form

Date

Position or Relationship to Client