Advanced Audiology of Greater Omaha-Adult Case History Form

Patient Name:_______________________________ DOB:________________ Date:______________

Primary Concern:
☐ Hearing Loss (Right ear/Left ear) ☐ Tinnitus/Ringing ☐ Dizziness

When did your symptoms begin? ____

1. Please mark any of the following that you currently have or have had in the past:

☐ Arthritis	☐ Heart Trouble	☐ STDs	☐ Parkinson's
☐ Ear Drainage	☐ Pacemaker	☐ Meningitis	☐ Scarlet Fever
☐ Ear Pain	☐ Lyme Disease	☐ Auto-Immune Disorder	☐ Migraines
☐ Ear Fullness / Pressure	☐ High Blood Pressure	☐ Mumps	☐ Sinusitis
☐ Sound Sensitivity	☐ HIV	☐ Hepatitis	☐ Stroke/TIA
☐ Vision Loss	☐ Thyroid Disorder	☐ Bell's Palsy	☐ Dementia
☐ Head Injury	☐ Diabetes	☐ Cancer	☐ MRI of the Head

2. Do you feel your hearing is changing? Yes No (Gradual ☐ Sudden ☐)

3. Have you been exposed to loud noise, either recently or in the past? ☐ Yes ☐ No
   If so, please mark all that apply:
   ☐ Farm Machinery ☐ Music ☐ Hunting/Shooting ☐ Factory Noise
   ☐ Power Tools ☐Military ☐ Jet Engines Other:

4. Have you seen an Ear, Nose, and Throat Physician? ☐ Yes ☐ No
   If so, whom did you see? _________________________________ When? ___________________________

5. Do you have a history of ear surgery? ☐ Yes ☐ No

6. Is there a history of hearing loss in your family? ☐ Yes ☐ No If yes, whom?___________________

7. Have you ever had an ear infection? ☐ Yes ☐ No (If yes: ☐ as a child ☐ as an adult)

8. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?
   ☐ Yes ☐ No If yes, describe: ____

9. Please list any prescription medications:
   Medication:_____________________________For:____
   Medication:_____________________________For:____
   Medication:_____________________________For:____
   Medication:_____________________________For:____

10. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
   ____Improved hearing in quiet ____Improved hearing in noise
   ____Cosmetic appearance ____Expense

11. If you are currently using a hearing aid, or have in the past, please answer the following:
Which ear is/was aided? ☐ Right ☐ Left ☐ Both
How long have you used a hearing aid? ______________________________
What would improve your current hearing aid? ______________________________

12. If you have tinnitus, ringing or noise in your ears or head, please complete this section:

Tinnitus is present in ☐ Both Ears ☐ Right Ear Only ☐ Left Ear Only

Does the tinnitus in one ear seem worse than the other? ______________________________

How long have you noticed your tinnitus? ______________________________

Did it begin suddenly or gradually? ______________________________

Is your tinnitus constant? Y or N

Describe the sound you hear: ______________________________

13. If you have dizziness/imbalance, please complete this section:

Describe your dizziness or imbalance ______________________________

When did these symptoms begin? ______________________________

Does anything trigger these symptoms? ______________________________

How many times have you fallen in the past 12 months? ______________________________

List any significant injuries from a fall: ______________________________

14. Previous Evaluations and Testing – If yes, please list location and date:

☐ Hearing Evaluation: ______________________________

☐ Tinnitus Evaluation: ______________________________

☐ Vestibular Evaluation: ______________________________

☐ Vestibular Evaluation: ______________________________

☐ MRI or CT Scan: ______________________________

☐ Cochlear Implant Evaluation: ______________________________