Jackson County Audiology – Case History

Patient Name: ______________________________ **DOB:** _________ **Date:** __________

YES	NO	QUESTION
		1. Chief complaint: Hearing Loss ___ (___ Right ear/___ Left ear), Tinnitus/Ringing ___, Dizziness ___ Difficulty hearing ___ (___In quiet/___ In noise)
		2. How long have you noticed this difficulty? ___________________________________
		3. Have you ever been exposed to loud noise through work or recreation, either recently or in the past?
		4. Do you have:
		a. A deformity of the ear?
		b. History of active drainage from the ear within the previous 90 days?
		c. History of sudden or rapidly progressive hearing loss within the previous 90 days?
		d. Acute or chronic dizziness?
		e. Hearing loss in one ear of sudden or recent onset within the previous 90 days?
		f. Pain or discomfort in the ear?
		g. Trouble hearing on the phone?
		5. Have you ever had any ear surgery?
		6. Is there a history of hearing loss in your family?
		a. If so, who? _______________________
		7. Have you ever had an ear infection, or any pain, pressure or drainage?
		a. If yes, as a child _______ or as an adult _____
		8. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness or vertigo?
		a. If yes, please describe: ____
		9. Have you seen an Ear, Nose, and Throat Physician?
		a. If so, who did you see? ________________________________ When? _______
		10. Please check any of the following that you currently have or have had in the past: ___ Arthritis ___ Heart Trouble ___ Measles ___ Parkinson's ___ Asthma ___ Hepatitis ___ Meningitis ___ Bell's Palsy ___ Sinusitis ___ Diabetes ___ High BP ___ HIV ___ Stroke ___ Head Injury ___ Neurological
		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 How long have you used a hearing aid? ___________ What would improve your current hearing aid? ________________________________

List prescriptions, over the counter, herbals, vitamin/dietary supplements on the back page, or attach a list.

Patient Name: ______________________________ **DOB:** _________ **Date:** __________

		12. Do you take any prescription medications on a regular basis? (or provide a complete list)
Route of delivery = route of administration such as oral, sublingual, injection, topical, inhalation, transdermal		a. If yes, please list all prescriptions, over the counter, herbals, vitamin/dietary supplements): Name: ______________ Dosage: ________ Frequency: __________ Route of delivery: ________ Name: ______________ Dosage: ________ Frequency: __________ Route of delivery: ________ Name: ______________ Dosage: ________ Frequency: __________ Route of delivery: ________ Name: ______________ Dosage: ________ Frequency: __________ Route of delivery: ________ Name: ______________ Dosage: ________ Frequency: __________ Route of delivery: ________ Name: ______________ Dosage: ________ Frequency: __________ Route of delivery: ________ Name: ______________ Dosage: ________ Frequency: __________ Route of delivery: ________ Name: ______________ Dosage: ________ Frequency: __________ Route of delivery: ________ Name: ______________ Dosage: ________ Frequency: __________ Route of delivery: ________ Name: ______________ Dosage: ________ Frequency: __________ Route of delivery: ________

Signature: ____________________________________ **Date:** ___________________________________