Coastal Audiology & Hearing Aid Center
ADULT CASE HISTORY

Date	**PATIENT INFORMATION**	Sex M F
Name		Age
Employer		
Occupation		Retired? Yes No

PURPOSE OF VISIT

RISK INDICATORS	**YES**	**NO**
Difficulty hearing?		
On a scale of 1-10, with 1 being the worst and 10 being the best, how would you rate your overall hearing ability? 1 2 3 4 5 6 7 8 9 10 (Please circle)		
Is one ear better than the other? Right or Left (Please circle)		
Do you wear hearing aids? Past or Currently (Please circle)		
Noises/ringing/buzzing in your ears (Tinnitus)?		
Dizziness?		
Ear pain, ear drainage, fullness or pressure in the ear?		
Allergies or sinus problems?		
Family history of hearing loss?		
History of military service? Branch_____ Years of Service_____		
Exposure to loud noises?		
Syndromes or developmental delay?		

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING	**YES**	**NO**
Cancer?		
Diabetes?		
Heart disease?		
High blood pressure?		
Kidney disease?		
Tobacco use?		

Please list any other chronic health conditions you are being treated or monitored for:

If you have your medications pre-printed on a list, we are happy to make a copy			
MEDICATIONS	**DOSAGE FREQUENCY**		**ORAL/INJECTED/TOPICAL, ETC.**
Include over-the-counter	What strength?	How often?	
DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING YOUR HEARING?			
IF HEARING AIDS, PERSONAL SOUND AMPLIFIERS, AND/OR HEARABLES ARE RECOMMENDED AT THE CONCLUSION OF TODAY'S VISIT, ARE YOU PREPARED TO TAKE THE NEXT STEPS TO PROCEED WITH THIS PLAN OF CARE?			