# 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: _____