ASHLAND AUDIOLOGY
PROFESSIONAL HEARING CARE

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Comprehensive Case History

Patient's Name: _____ **Today's Date**: _____

Date of Birth: _____ **Gender**: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student **Are you a Veteran?** ☐ Yes ☐ No

Current Employer: _____ **Position**: _____

If retired, previous Employer _____ **Position:** _____

Highest Level of Education: _____ **E-mail Address:** _____

Family Doctor: _____ **Clinic:** _____ **Pharmacy:** _____

How did you hear about us? _____

Why are you here today? _____

Have you tested positive for COVID-19? ☐ No ☐ Yes **If yes, when?** _____

Please check all medical conditions that apply

☐ Allergies: (Food, Medications, etc.)_____

☐ Developmental Disorders/Delays Please explain: _____

☐ Ear Deformity Right Ear☐ Left Ear☐ Both Ears☐

☐ Ear Drainage Right Ear☐ Left Ear☐ Both Ears☐

☐ Ear Pain Right Ear☐ Left Ear☐ Both Ears☐

☐ Ear Noises/Ringing in Ears Right Ear☐ Left Ear☐ Both Ears☐ How Often? _____

☐ Family History of Hearing Loss Who: _____ Age: _____

☐ History of Ear Infections Right Ear☐ Left Ear☐ Both Ears☐ When? _____

☐ History of Wax Build-Up

☐ History of Noise Exposure Describe:_____

☐ Previous Ear Surgery Right Ear☐ Left Ear☐ Both Ears☐ When? _____

☐ Unsteadiness or Dizziness Accompanied by: Vomiting☐ Nausea☐ Ear Noises☐

☐ Other Describe: _____

-OVER-

Audiologic History

Do you experience hearing loss? Yes☐ No☐ **If yes, which ear**? Right Ear☐ Left Ear☐ Both Ears☐

If you experience hearing loss, which best describes it? Gradual☐ Sudden☐

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Have you ever had a hearing test? Yes☐ No☐ **If yes, when**? _____ **Where?** _____

Which ear do you use when you talk on the phone? Right Ear☐ Left Ear☐ Both Ears☐

Have you ever worn or tried a hearing aid? Yes☐ No☐ Right Ear☐ Left Ear☐ Both Ears☐

What type and/or style of hearing aid: _____

Please describe your experience: _____

If the result of our evaluation today indicates hearing aids could help you, are you interested in discussing them? Yes☐ No☐ Maybe☐

Have you experienced any of the following medical conditions? Check all that apply.

☐ AIDS/HIV	☐ Headaches	☐ Measles
☐ Arthritis	☐ Head Injury	☐ Meningitis
☐ Blood Disorders	☐ Heart Problems	☐ Mumps
☐ Cancer	☐ High Blood Pressure	☐ Scarlet Fever
☐ Chicken Pox	☐ High Fevers	☐ Stroke
☐ Diabetes	☐ Influenza	☐ Tonsillitis
☐ Genetic Disorders	☐ Kidney Problems	

Head, Neck or Ear Surgeries: _____

_____

Audiologist's Notes: