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 or someone in your home 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:____

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Audiologist's Notes: