ETSUHealth
COLLEGE OF CLINICAL AND REHABILITATIVE HEALTH SCIENCES

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Patient Name: ______________________________ DOB: ____________ Date: __________

CASE HISTORY QUESTIONNAIRE

Who referred you to this clinic? ______________________________

Have you had your hearing tested previously? ☐ YES or ☐ NO
If YES, please describe when and where: ______________________________

Do you feel that you have hearing loss? ☐ YES or ☐ NO
If YES, Please check any that may apply.

- ☐ Difficulty understanding people
- ☐ Trouble hearing the T.V.
- ☐ Trouble hearing on the telephone
- ☐ Often needing things repeated
- ☐ Trouble hearing with background noises (restaurants, etc.)
- ☐ Other:______________________________

Hearing loss that was: ☐ gradual or ☐ sudden. When did it start?________________
My ☐ Right or ☐ Left ☐ both ear(s) is/are worse.
Do you know why one ear may be worse than the other? ______________________

Otologic History:

Please check all that may apply:

- ☐ Recent ear infection
- ☐ Pain/Pressure/Drainage
- ☐ PE Tubes
- ☐ History of ear infections
- ☐ Ear Surgery
- ☐ Other:

If you marked YES for any of the above, please explain/describe:

____

Please list your current medications and their dosage, and what they are taken for below:

____

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Have you ever worn hearing aids? ☐ YES ☐ NO
If YES, how long have you worn hearing aids? ______________________________
How old are your current hearing aids? ______________________________
Where did you get your last set of hearing aids? ______________________________
What kind of hearing aids do you have? ______________________________

Tinnitus:

Do you have any ringing/roaring/buzzing/sounds in your ears? ☐ YES ☐ NO
Do noise and certain sounds cause you stress, irritation, or pain? ☐ YES ☐ NO
If YES, please describe:

____

Would you be interested in tinnitus counseling? ☐ YES ☐ NO

Dizziness:

Do you have trouble with dizziness or imbalance? ☐ YES ☐ NO

If YES, please describe:

____

Medical History:

PLEASE Check all that apply:

- ☐ High blood pressure
- ☐ Neuropathy
- ☐ Heart Surgery
- ☐ Vision problems
- ☐ Diabetes
- ☐ Cancer
- ☐ Pace Maker/Defibrillator
- ☐ Other:____________________

Please describe:

____

____

History of Noise Exposure:

Military Service

Branch and time of service:______________________________

Were you ever been exposed to loud sounds in the Military? ☐ YES ☐ NO

PLEASE check all that apply:

- ☐ Gunfire
- ☐ Artillery
- ☐ Heavy Machinery
- ☐ Aircraft
- ☐ Explosions
- ☐ Other:

Was hearing protection provided/worn? ☐ YES ☐ NO ☐ SOMETIMES

Occupational

Have you been exposed to loud sounds at your job? ☐ YES ☐ NO

If YES, please describe:______________________________

Was hearing protection provided/worn? ☐ YES ☐ NO ☐ SOMETIMES

Recreational

Have you been exposed to loud sounds recreationally? ☐ YES ☐ NO

PLEASE check all that apply:

- ☐ Hunting
- ☐ Target shooting
- ☐ NASCAR
- ☐ Riding lawn mower
- ☐ Power tools
- ☐ Heavy machinery
- ☐ Motorcycles
- ☐ Other:____________________

Was hearing protection provided/worn? ☐ YES ☐ NO ☐ SOMETIMES

If there is anything you feel has been missed in this questionnaire, please add medical or relevant information you feel is important for the audiologist to know:

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