

Adult Case History
Audiology Department
Braintree Rehabilitation Hospital

A. Identification:

1.) Name: _____

2.) Primary Care Physician: _____

3.) Referred By: _____

4.) Describe Problem: _____

B. Medical History:

1. Any illness? _____

If yes, please describe: _____

2. Any history of ear infections? Yes No History of ear surgery? Yes No

If yes, please describe: _____

3. Do you have a feeling of pain or fullness in your ear(s)? Yes No

If yes, please describe: _____

4. Drainage from ear(s)? Yes No

If yes, please describe: _____

5. Have you had any dizziness? Yes No

Which of the following best describes your dizziness?

__ The room seems like it's spinning and I'm still __ I feel like I am going to fall down

__ I feel like I am spinning and the room is still __ I feel lightheaded

__ I feel sick to my stomach __ I feel off-balance in space

__ Other (describe) _____

When did you start feeling dizzy? _____

6. Do you hear any noises in your ear(s)? Yes No

The noises are in the: Right ear ___ Left ear ___ Both ears ___

The noises are present: Sometimes ___ Often ___ Always ___

When did you start having the noises? _____

Describe the noises: Roaring ___ Ringing ___ Buzzing ___ Pulsing ___ Chirping ___

Hissing ___ Humming ___ Other _____

7. Have you ever been exposed to loud noises? Yes No

Please indicate the type(s) of noise:

- | | | |
|--------------------------------------------|--------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Gunfire | <input type="checkbox"/> Motorcycles | <input type="checkbox"/> Explosions |
| <input type="checkbox"/> Power lawn mowers | <input type="checkbox"/> Factory noise | <input type="checkbox"/> Aircraft |
| <input type="checkbox"/> Power tools | <input type="checkbox"/> Loud music | <input type="checkbox"/> Heavy equipment |
| <input type="checkbox"/> Military tanks | <input type="checkbox"/> Other types _____ | |

Are you exposed to noise daily? Yes No

8. Have you seen an ENT specialist? Yes No

If yes, please describe: _____

C. Communicative Situations

1. Do you have any problems hearing? Yes No

Which ear? Right ___ Left ___ Both ___

When did you first notice it? _____

Has the hearing loss been: Sudden ___ Gradual ___ Fluctuating ___

2. Three of your most difficult listening situations are:

- a.
- b.
- c.

3. Does your hearing loss interfere with communication? Yes No

If yes, describe: _____

D. Hearing Aids

Check all that apply

I do not own a hearing aid; I am interested in finding out if one can help

I do not own a hearing aid; I am not interested in getting a hearing aid at this time
because: _____

I own a hearing aid now but I do not use it because: _____

I owned a hearing aid at one time; I quit using the hearing aid because: _____

(Do not complete below this line)

Criteria:

1. Otolgia
2. Inflammation of the ear
3. Foul smelling or purulent aural drainage
4. Otitis media
5. Vertigo-Initial evaluation/recent onset
6. Tinnitus-Initial evaluation/recent onset
7. Blocked feeling in ear
8. Balance disturbance
9. Spontaneous nystagmus
10. Symptoms associated with ototoxic drugs
11. Impacted cerumen
12. Neurological evaluation
13. Meniere's disease
14. Asymmetrical hearing loss-Initial evaluation/recent onset
15. Sudden hearing loss initial evaluation/recent onset
16. Perforated tympanic membrane