COLORADO SPRINGS AUDIOLOGY, Inc.

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CASE HISTORY FOR ADULT AUDIOLOGY EVALUATION

Patient Information Date_____________________

Person completing this form ☐ Self ☐ Other (relationship to patient) ___________________________

Patient's Name ____________________________ SS#____________________
LAST FIRST MI NICKNAME

Birthdate _____/_____/___________ Age ________ Gender: ☐ Male ☐ Female Marital Status: ☐S ☐M ☐D ☐W

Address ____
STREET CITY STATE ZIP

Phone ____
HOME BUSINESS CELL EMAIL

Occupation: ☐Working ☐Retired ☐N/A_______________________________
JOB TITLE EMPLOYER

Reason for visit: ___________________________ Referred by: _______________________

Family Physician ____

Address_______________________________________ Phone__________________

Financial Information

Payment is: ☐Private ☐Insurance ☐Medicaid ☐Medicare ☐Other___________________________

Please be aware that while you may be Medicare eligible, Medicare will not pay for hearing aids, nor will it pay for any tests that are associated with the purchase of hearing aids.

Description of Hearing Loss

Do you think you have a hearing problem? ☐Yes ☐No. *If "no" skip to next section*

When did you first notice problems with your hearing? ____Years Ago ____ Months Ago

Do you think the onset of your hearing loss was: ☐Sudden ☐Gradual ☐Very gradual

Do you hear better in one ear? ☐Right ear ☐Left ear ☐No or not sure

List the situations where you have most trouble ____
____

BECAUSE OF YOUR HEARING PROBLEM:

Do you ever feel embarrassed when meeting new people?	☐Yes	☐No	☐Sometimes
Do you ever feel frustrated when talking to family members?	☐Yes	☐No	☐Sometimes
Do you have difficulty when someone speaks in a whisper?	☐Yes	☐No	☐Sometimes
Do you feel "handicapped" or disable?	☐Yes	☐No	☐Sometimes
Are you less likely to attend church due to hearing loss?	☐Yes	☐No	☐Sometimes
Do you ever have family arguments?	☐Yes	☐No	☐Sometimes
Do you have difficulty understanding friends and family?	☐Yes	☐No	☐Sometimes
Do you have difficulty listening to T.V. programs?	☐Yes	☐No	☐Sometimes
Is your personal or social life restricted in any way?	☐Yes	☐No	☐Sometimes
Do you have trouble hearing in restaurant?	☐Yes	☐No	☐Sometimes

Have you ever had your hearing tested before? ☐Yes ☐No

If yes, when and where?
____

What you were told?
____

Tinnitus and balance problems

Do you experience noises (ringing or buzzing) in your ears? ☐Yes ☐No

If "yes" which ear(s) ☐Right ear ☐Left ear ☐Both ears or unsure

Do you experience dizziness, light-headedness or vertigo? ☐Yes ☐No

If yes, please complete the following:

My dizziness is best described as: ☐light headedness ☐a spinning sensation ☐unsteadiness

How long does the dizziness last: ☐few seconds ☐few minutes ☐about an hour ☐1-4 hours ☐continuously

Family History of hearing loss

Please check any relatives who developed hearing loss prior to age 40:

___ Mother	___ Father	___ Grandfather (s)	___ Grandmother(s)
___ Brother(s)	___ Sister(s)	___ Aunt (s)	___ Uncles(s)
___ Cousins	___ Nephew(s)	___ Nieces(s)	___ Other

Medical History

In general, would you say your health is ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

Do you smoke or did you use to smoke? ☐Yes, currently smoke ☐Yes, but quit ☐No

Are you allergic to latex? ☐Yes ☐No

Please check if you have ever had or currently have any of the following medical conditions?

___ Kidney problems	___ Liver problems	___ Diabetes	___ Genetic disorder
___ Arthritis	___ Sinus problems	___ High blood pressure	___ Breathing problems
___ Heart problems	___ Allergies	___ Head injuries	___ Limited dexterity
___ Bleeding problems	___ Stroke	___ HIV/AIDS	___ Other

Medications

Drug Name	Dosage	Reason
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Ear History

Please check all of the following that apply to you:

☐Had many ear infections as a child
☐Currently experiencing frequent ear infections
☐Have had one or more ear surgeries
☐Currently have drainage from one or both ear(s)

If you checked any of the above, please explain: ____

____

Noise History

Please check all of the following that apply to you:

☐Military service
☐Factory noise
☐Construction work
☐Farming
☐Hunting/firearms
☐Musician
☐Pilot
☐Airline industry employment
☐Other

If you checked any of the above, please explain: ____

____

Hearing Aids

Do you currently wear or have hearing aids? ☐Yes ☐No

If "no", skip the rest of the questions in this section

How old were you when you began using hearing aids?____

If currently using hearing aids, which ear or ears? ☐Right ☐Left ☐Both

If "both," were they purchased at the same time? ☐Same time ☐Different times

Where did you purchase your hearing aids?

____

How old is/are your current hearing aid(s)____

What style of hearing aid do you have?
☐In the ear (ITE)
☐In the canal (ITC)
☐Completely in the canal (CIC)
☐Behind the ear (BTE)

Are your hearing aids analog or digital? ☐ Analog ☐Digital ☐Unsure (don't know)

Do you use your hearing aids daily? ☐Yes ☐No

Are you benefiting from your hearing aids? ☐Yes ☐No

Briefly explain why you feel, or do not feel you are benefiting from the use of your hearing aids

____

____

Authorization to render services

With your signature below, you permit Dr. McHugh and staff to render services. Dr. McHugh is a clinical audiologist, NOT a medical doctor. Audiologists are the professionals trained to best evaluate your hearing and hearing aids needs. Audiologists possess a minimum Master's degree in audiology and some also have doctoral degrees within their area of expertise. If you would prefer to see a physician to rule out a medical problem before trying hearing aids, we will refer you to your family physician.

______________________________________ ______________________________

Signature of patient or guardian Today's date