ADULT CASE HISTORY FORM

FULL NAME: **DOB:** **DATE:**

A. GENERAL INFORMATION

1. What is your main reason for attending the clinic?

2. How would you rate your overall hearing ability? *(Please circle)*

WORST	1	2	3	4	5	6	7	8	9	10	BEST

3. How important is it for you to do something about your hearing? *(Please circle)*

LOW	1	2	3	4	5	6	7	8	9	10	HIGH

4. Do you have difficulty hearing speech or conversation in any of the following situations: *(Please tick all that apply)*

- ☐ One on one
- ☐ Watching TV
- ☐ Telephone conversations
- ☐ Small groups (2-4 people)
- ☐ Restaurants & cafés
- ☐ Outdoor activities
- ☐ Shopping centers
- ☐ Large groups (5-10)
- ☐ Soft speakers
- ☐ In the car
- ☐ Meetings
- ☐ Noisy social events (10+)
- ☐ Other:

B. EAR HISTORY *(Please tick yes or no)*

1. Do you think you have a hearing loss?	◯ Yes	◯ No	***If YES**, when did you start noticing the problem?*
2. Do you hear better in one ear over the other?	◯ Yes	◯ No	***If YES**, which ear is better?* ☐ R ☐ L
3. Ringing / buzzing in your ears (tinnitus)	◯ Yes	◯ No	***If YES**, which side?* ☐ R ☐ L
4. Do you have a history of significant noise exposure (work or hobby related)?	◯ Yes	◯ No	***If YES**, how long and describe the type of exposure?*
5. Have you experienced dizziness (vertigo) in the last 6 months?	◯ Yes	◯ No	
6. Is there a history of hearing loss in your family, before the age of 50?	◯ Yes	◯ No	
7. When was the last time you had your hearing tested?	Estimated date:		

C. MEDICAL HISTORY RELATED TO YOUR HEARING *(Please tick all that apply)*

- ☐ Ear pain
- ☐ Discharge
- ☐ Ear Infection, Date Last:
- ☐ Grommets
- ☐ Perforation of the eardrum
- ☐ Fullness in the ear
- ☐ Otosclerosis
- ☐ Meniere's Disease
- ☐ Acoustic Neuroma
- ☐ Other:
- ☐ Ear Surgeries (Please list):

D. GENERAL MEDICAL HISTORY *(Please tick all that apply)*

- ☐ Diabetes Mellitus
- ☐ Cholesterol
- ☐ High blood pressure
- ☐ Allergies
- ☐ Sinus problems
- ☐ Stroke
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Arthritis
- ☐ Heart problems
- ☐ Pacemaker
- ☐ Memory issues
- ☐ Serious Head Injury
- ☐ Vision Impairment
- ☐ Poor dexterity
- ☐ Other

E. HEARING AID HISTORY

1. Have you ever worn or tried hearing instruments? ◯ Yes ◯ No

*If **YES**, please answer the questions below:*

(a) When did you start wearing hearing aid/s?

(b) How long have you had your most current hearing aid/s?

(c) Do you benefit from the hearing aids? ◯ Yes ◯ No

(d) How often do you wear your hearing aids?

THANK YOU FOR ENTRUSTING US WITH YOUR HEARING CARE

Save and Email your completed form to info@noosahearing.com.au
or print and bring it with you to your appointment.

Save Print