DR. JULIE ESCHENBRENNER, AU.D.
DOCTOR OF AUDIOLOGY

COMPREHENSIVE CASE AND AUDIOLOGIC HISTORY FORM

____

Patients Name:

____

Date of Completion:

____

Date of Birth:

Do you experience hearing loss? ❑ yes ❑ no

If yes, in which ear? ❑ Right ❑ Left ❑ Both

If you experience hearing loss, how would you best describe it? ❑ Gradual ❑ Fluctuating ❑ 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 so, when? ____

Which ear do you use to talk on the phone? ❑ Right Ear ❑ Left Ear ❑ Both Ears

Have you ever worn or tried a hearing aid? ❑ Right Ear ❑ Left Ear ❑ Both Ears

If yes, what type/or style of hearing aid: ____

Please describe your experience: ____

____

____

____

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DO YOU STILL EXPERIENCE ANY OF THE FOLLOWING WITH YOUR CURRENT HEARING AID (Please check all that apply):

❑ Some sounds are too loud	❑ Trouble understanding in quiet	❑ Trouble understanding in noise
❑ Sounds are too soft	❑ Wind noise	❑ Do no like the appearance of hearing aid
❑ Pain	❑ Trouble using telephone	❑ Do no like the sound of own voice
❑ Sounds of tinny or metallic	❑ Feeback or whistling	❑ Cannot tell direction of sound
❑ Cleaning hearing aid	❑ Changing battery	❑ Battery life
❑ Naturalness of sound	❑ Repair issues	❑ Other ______________________

PLEASE CHECK ALL MEDICAL CONDITIONS THAT APPLY:

❑ Development Disorders/Delay — If checked, please explain: ______________________

❑ Dizziness or Unsteadiness — If checked, is it accompanied by: ❑ Vomiting ❑ Nausea ❑ Ear Noises

❑ Ear Deformity — If checked, ❑ Right ear ❑ Left ear ❑ Both ears

❑ Ear Pain — If checked, ❑ Right ear ❑ Left ear ❑ Both ears

❑ Family History of Hearing Loss — If checked, who: ______________________

❑ History of Ear Infections — If checked, ❑ Right ear ❑ Left ear ❑ Both ears When? ____________

❑ History of Ear Wax Buildup

❑ History of Noise Exposure — If checked, please describe: ______________________

❑ Previous Ear Surgery — If checked, ❑ Right ear ❑ Left Ear ❑ Both ears When? ____________

❑ Tinnitus/Ringing/Noises in Ears — If checked, ❑ Right ear ❑ Left ear ❑ Both ears Frequency? ____________

❑ Other: — Please describe: ______________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Question			
Does a hearing problem cause you to feel embarrassed when you meet new people?	❑ Yes	❑ Sometimes	❑ No
Does a hearing problem cause you to feel frustrated when talking to members of your family?	❑ Yes	❑ Sometimes	❑ No
Do you have difficulty when someone speaks in a whisper?	❑ Yes	❑ Sometimes	❑ No
Do you feel handicapped by a hearing problem?	❑ Yes	❑ Sometimes	❑ No
Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	❑ Yes	❑ Sometimes	❑ No
Does a hearing problem cause you to attend religious services less often than you would like?	❑ Yes	❑ Sometimes	❑ No
Does a hearing problem cause you to have arguments with family members?	❑ Yes	❑ Sometimes	❑ No
Does a hearing problem cause you difficulty when listening to TV or radio?	❑ Yes	❑ Sometimes	❑ No
Do you feel any difficulty with your hearing that limits or hampers your personal or social life?	❑ Yes	❑ Sometimes	❑ No
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	❑ Yes	❑ Sometimes	❑ No

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MEDICAL HISTORY

Any other illnesses, surgeries, injuries, or hospitalizations since birth and their date(s) of occurrence

____

____

____

Allergies (food, medications, plastics, etc.):

____

____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING MAJOR MEDICAL CONDITIONS? (Please check all that apply:)

- ❑ AIDS/HIV
- ❑ Appetite Change
- ❑ Arthritis
- ❑ Blood Disorders
- ❑ Cancer
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Encephalitis
- ❑ Fatigue
- ❑ Genetic Disorders
- ❑ Headaches
- ❑ Head Injury
- ❑ High Blood Pressure
- ❑ High Fevers
- ❑ Influenza
- ❑ Malaise
- ❑ Malaria
- ❑ Measles
- ❑ Mumps
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Tonsillitis
- ❑ Typhoid
- ❑ Other: ______________________________
- ❑ Chicken Pox
- ❑ Heart Problems
- ❑ Meningitis

Current Medications (over the counter and prescriptions). Please include dosage and route: ______________________________

____

____

Have you been immunized? ❑ yes ❑ no

If yes, for what illnesses or diseases? ______________________________

PLEASE CHECK ALL MEDICAL SYMPTOMS THAT APPLY:

Eye problems (such as blurred vision, pain):	❑ yes	❑ no
Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain):	❑ yes	❑ no
Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations):	❑ yes	❑ no
Respiratory Symptoms (such as shortness of breath, cough, wheezing):	❑ yes	❑ no
Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma):	❑ yes	❑ no
Neurological Symptoms (such as numbness, headaches, seizures, muscle weakness):	❑ yes	❑ no
Psychiatric Issues (such as depression anxiety, compulsions):	❑ yes	❑ no
Endocrine Symptoms (such as frequent urination, hot flashes):	❑ yes	❑ no
Hematologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands):	❑ yes	❑ no
Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency):	❑ yes	❑ no

Do you currently use recreational drugs?	❑ yes	❑ no			
If yes, what drugs and how often:	❑ Daily	❑ Weekly	❑ Monthly	❑ Occasionally	❑ Rarely
Do you currently use tobacco?	❑ yes	❑ no			
If yes, what do you smoke:	❑ Cigarettes	❑ Cigars	❑ Pipe	❑ Smokeless	Other: ______
If yes, amount per day:					
Do you currently drink alcoholic beverages?	❑ yes	❑ no			
If yes, how often?	❑ Daily	❑ Weekly	❑ Monthly	❑ Occasionally	❑ Rarely