

Northwest Ohio Hearing Clinic

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Adult Case History – Audiology

Today's Date _____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____ Gender: Male Female

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Other Phone _____

Email Address _____ Family Physician _____

Whom may we thank for referring you? _____

Reason for visit? _____

Where would you like us to send a copy of your results? _____

Who may we discuss your results with? _____

Please check the appropriate answer:

Yes No

___ ___ Do you feel hard of hearing? If so, which ear? Right Left Both

For how long? _____ Is the problem becoming worse? Yes No

___ ___ Do you have noises in your ears? If so, which ear? Right Left Both

What does it sound like? Ringing Clicking Buzzing Other _____

___ ___ Have you recently experienced pain or drainage from your ears? Right Left Both

___ ___ Do your ears feel plugged? If so, which ear? Right Left Both

___ ___ Do you have dizzy spells? If so, when was the last spell? _____

Please describe _____

___ ___ Have you ever had an operation on your ears? If so, which ear? Right Left Both

What type of surgery? _____

___ ___ Do you have any difficulties with your sense of touch or handling small objects?

___ ___ Do you have any serious vision problems? If so, what type? _____

Yes No

___ ___ Is there a family history of hearing loss, such as your parents, brothers or sisters?
If so, what type and whom? _____

___ ___ Have you ever worked around loud noises?
___ ___ If so, did you wear ear protection?
How long have you worked around loud noise? _____
What type of noise? (please circle) factory work power tools military
construction other? _____

___ ___ Do you have any noisy hobbies?
___ ___ If so, do you wear ear protection?
What type of noise? (please circle) firearms loud engines loud music
carpentry other? _____

___ ___ Have you ever worn a hearing aid? Which ear? Right Left Both
What type of hearing aid do you have? _____
How long have you had your hearing aids? _____

___ ___ Have you ever been exposed to any hazardous chemicals?

Please list any medications you are currently taking _____

Which of the following types of medications have you taken? (Indicate dosage and length of time taking)

___ Diuretics – _____ ___ Anti-inflammatory - _____
___ Chemotherapy – _____ ___ Antibiotics - _____
___ Radiation - _____

Please check any of the following health problems you have experienced (check all that apply)

___ Head Trauma/Traumatic Brain Injury	___ Cytomegalovirus (CMV)
___ Frequent Ear Infections	___ Syphilis
___ Developmental Disability	___ Hepatitis (A,B, or C)
___ Stroke	___ Heart Disease or High Blood Pressure
___ Cerebral Palsy	___ Kidney Disease
___ Frequent Severe Headaches or Migraine	___ Arthritis
___ Diabetes	___ Parkinson's Disease (Tremors)
___ Meningitis	___ Alzheimer's Disease or Dementia
___ Scarlet Fever or Prolonged Low Fever	___ Seizure Disorder
___ Cleft Palate	___ Immune Deficiency Disorder
___ Temporomandibular Joint Disease (TMJ)	___ Other Neurological Disease _____
___ Other disease of the ear? _____	___ Cancer – Type? _____