HEARING DOCTORS OF HAWAI`I , LLC

Adult Case History

Date:_____

Patient Name:_____Birthdate:___/___/___ Gender: ___Male___Female

Patient's Occupation:_____ Referred By:_____

If the question does not apply please leave blank or write N/A

Hearing History:

1. Reason for visit/ Description of Problem:_____

_____

_____

2. Do you think you have a hearing loss?____No,____Yes: When did it begin?_____

3. If yes, do you have a better ear? R/L?_____

4. When did you notice your hearing loss and did it begin gradually or rapidly? Is it progressive?_____

_____

5. Have you ever had your hearing tested? ____No, ____Yes: If yes, when?_____

Where?_____ Results?_____

_____

6. Any family history of hearing loss?____No;_____Yes; Please list relationship/age of onset/cause of hearing loss, if known:_____

_____

7. History of loud noise exposure? ___No,___Yes; Describe:_____

_____For how long?_____Did you use ear protection?_____

8. Do you have any ringing/buzzing or noises in your ears?____No,_____Yes: If yes, which ear(s)/onset?

Describe_____

9. Are you experiencing dizziness/vertigo?____No,_____Yes: Describe(onset/frequency/position related)_____

_____

10. Any pain or discomfort in your ears (including fullness/drainage)?_____No,____Yes: Describe_____

_____

11. Do loud sounds bother you?____No, _____Yes:_____

*******Please continue on other side*******

11. Does you hearing loss affect you ability to: (circle)

Hear in quiet?	YES	NO	Hear in noise?	YES	NO
Hear at home?	YES	NO	Hear at work?	YES	NO
Hear the television?	YES	NO	Hear on the phone?	YES	NO

12. Have you ever worn a hearing aid? ____No,____Yes: Right/left/both?_____

Type? _____ How did it benefit you?_____

When/where obtained?_____How long did you use it?_____

13. If you have not worn a hearing aid, do you think you might need one? _____No,_____Yes

Medical History:

1. Please circle any of the following you currently have or have had in the past?

Diabetes	Stroke	Meningitis	Arthritis	Parkinson's
Malaria	Cancer	Measles	Mumps	Sinusitis
Stroke/TIA	High Blood Pressure	HIV	Hepatitis	Heart trouble
Vision trouble/loss	Neurological symptoms		Excessive Bleeding	

Others/describe:_____

2. Any head injuries or seizures?____No,____Yes: Type/When?_____

3. Any history of ear infections?___No,____Yes: when was the first infection?_____

When was the most recent infection?_____ How many total?_____

How treated?_____

4. Any eardrum perforations/trauma?____No,____Yes:_____

5. Any ear surgeries(including PE tubes)?___No,___Yes: Type of Surgery/When:_____

_____Right/left/both ears?

6. Any other surgeries?___No,____Yes: Type/when?_____

_____

7. Any allergies?___No,____Yes: List_____

8. Are you taking any medication(s)?___No,____Yes: List_____

_____

Any other concerns/important info:_____

_____

Thank you!!!