WACO Hearing Center

254.878.4040
www.WacoHearingCenter.com

Adult Case History

Please Print Today's Date: _____

Full Name: _____ Preferred Name: _____

Birth Date: _____ Gender: _____

Mobile Phone: _____ Alternate Phone: _____

Place of Employment: _____

How would you prefer to be contacted: (please check one)
☐ Phone ☐ US Mail ☐ Email

Spouse/Caregiver Name: _____ Phone: _____

Family Physician: _____ Referred by: _____

Please check the appropriate answer. Fill in blanks where indicated.

YES	NO	
☐	☐	Do you feel you have difficulty hearing? If so, which ear? ☐ Right ☐ Left ☐ Both For how long? _____ Is the problem becoming worse? ☐ Yes ☐ No
☐	☐	Do you have trouble understanding people when they talk?
☐	☐	Have you recently experienced pain or drainage in your ears?
☐	☐	Have you ever had bleeding from your ears? If so, which ear? ☐ Right ☐ Left ☐ Both
☐	☐	Do you have noises in your ears? Which ear? ☐ Right ☐ Left ☐ Both What does it sound like? ☐ Ringing ☐ Clicking ☐ Buzzing ☐ Other _____
☐	☐	Do your ears feel plugged? If so, which ear ☐ Right ☐ Left ☐ Both
☐	☐	Do you have dizzy spells? If so, when was the last one? Please describe: _____
☐	☐	Have you ever had an operation on your ears? If so, which ear? ☐ Right ☐ Left ☐ Both What type of surgery? _____
☐	☐	Have you ever had a doctor remove wax from your ears? If so, how long ago? _____ Which ear? ☐ Right ☐ Left ☐ Both
☐	☐	Is there a family history of hearing loss, such as in 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 loud noise? ☐ Factory Work ☐ Construction ☐ Farm Machinery ☐ Motorcycles ☐ Loud Engines ☐ Power Tools ☐ Loud Music ☐ Lawnmowers ☐ Military Artillery

Please check the appropriate answer. Fill in blanks where indicated.

YES NO

☐ ☐ Do you have any noisy hobbies?
If so, do you wear ear protection? _____
What type of loud noise? ☐ Motorcycles ☐ Dirt Bikes ☐ Carpentry ☐ Power Tools
☐ Loud Engines ☐ Loud Music ☐ Gunfire ☐ Other _____

☐ ☐ Have you ever worn a hearing aid? For which ear? ☐ Right ☐ Left ☐ Both
If so, when did you obtain it/them? _____
What concerns do you have about your hearing aids? _____

☐ ☐ 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? _____

☐ ☐ Do you use tobacco products?

Please indicate whether you have had any of the following health problems: *(Please check all that apply)*

☐ Allergies
☐ Sinusitis
☐ Meningitis
☐ Scarlet Fever or Prolonged Low Fever
☐ Prolonged High Fever
☐ Mumps
☐ Measles
☐ Tuberculosis (TB)
☐ Cytomegalovirus (CMV)
☐ Syphilis
☐ Hepatitis (A, B or C)
☐ Diabetes
☐ Heart Disease or High Blood Pressure
☐ Hypothyroidism
☐ Kidney Disease
☐ Frequent Ear Infections

☐ Arthritis
☐ Tremors (e.g., Parkinson's Disease)
☐ Multiple Sclerosis
☐ Cerebral Palsy
☐ Traumatic Brain Injury/Head Trauma
☐ Stroke, Brain Attack, TIA or CVA
☐ Alzheimer's Disease or Dementia
☐ Concussion or Loss of Consciousness
☐ Seizure Disorder
☐ Other Neurological Disease
☐ Frequent Severe Headaches or Migraine
☐ Developmental Disability
☐ Temporomandibular Joint Disorder (TMJ)
☐ Cleft Palate
☐ Immune Deficiency Disorder
☐ Cancer - What type? _____

☐ Other Disease of the Ear: _____

What medications are you currently taking? _____

_____

_____

Which of the following types of medications have you taken?

☐ Diuretics
☐ Antibiotics
☐ Blood Pressure/Heart Medication
☐ Antimalarial Medication

☐ Anti-inflammatory or Arthritis Medication
☐ Chemotherapy
☐ Cholesterol-Lowering Medication
☐ Immunosuppressant, e.g., Transplant Medication