ADULT CASE HISTORY

Patient Information

Name: _____
Title (Mr., Mrs., Miss, Ms., etc.) First Name Middle Name Last Name Suffix (Jr., Sr., II, III, etc.) Preferred Name

Birthdate: _____ Sex (circle one): Male Female Phone: _____

Email Address: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact (Name, Phone # and Relationship): _____

Primary Care Physician: _____ Phone: _____

Primary Insurance Information

Insurance Company Name: _____

Patient Relation to Insured (circle one): Self Spouse Child Other: _____

Email Address: _____ Address: _____

Subscriber/Member ID: _____ Group: _____

Secondary Insurance Information

Insurance Company Name: _____

Patient Relation to Insured (circle one): Self Spouse Child Other: _____

Email Address: _____ Address: _____

Subscriber/Member ID: _____ Group: _____

Patient History

Chief Complaint: Difficulty Hearing – Right Left Both Tinnitus/Ringing – Right Left Both Dizziness/Vertigo

Other Symptoms: Difficulty Hearing – Right Left Both Tinnitus/Ringing – Right Left Both Dizziness/Vertigo

How did your symptoms begin: Gradually Sudden (within past 90 days) Fluctuating Sudden (longstanding)

How long have you noticed this difficulty? _____

What do you think caused your symptoms? _____

Please list dates and locations of prior hearing tests and bring copies to your appointment if available:

_____

Please circle any types of loud noise you have been exposed to, either recently or in the past:

Occupational Shooting – Right-handed or Left-handed Military Recreational Other: _____

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Please select all members of your family that have/had hearing loss:

Mother Father Sibling Grandparent Aunt/Uncle/Cousin Other: _____ None

Please select any of the following that has occurred in the past 90 days:

Drainage from the ear Ear pain Ear fullness/pressure Sudden or rapidly progressive hearing loss – Right Left Both None

Have you had ear infections or surgeries on your ears?

Infections Surgeries Right Left Both None

Please describe any dizziness, lightheadedness or vertigo you have experienced: _____

Falls within the past 12 months:

One fall without injury One fall with injury Two or more falls None

General Medical History

Have you experienced any of the following major medical conditions (please circle all that apply):

AIDS	Depression	HIV	Rheumatoid
Alzheimer's Disease	Diabetes-Insulin Y/N	Influenza	Scarlet Fever
Anemia	Diabetes-Type 1 or 2	Kidney Disease-Stage: _____	Sinusitis
Anxiety	Diphtheria	Loneliness	Stroke
Appetite Change	Encephalitis	Lung Disease	Thyroid Disease
Arthritis/Rheumatoid	Fatigue	Malaise	TIA
Asthma	Genetic Disorders	Malaria	Tonsillitis
Bell's Palsy	Headaches	Measles	Tooth Decay
Blood Disorders	Head Injury	Meningitis	Typhoid
Cancer	Heart Disease	Mumps	Vascular Problems
Chicken Pox	Hepatitis	Neurological Symptoms	Worry
Cognitive Decline	High Blood Pressure	Obesity	Other: _____
COPD	High Cholesterol	Osteoporosis	
Dementia	High Fevers	Parkinson's	

Please list any major illnesses, injuries, surgeries and hospitalizations: _____

Please list any allergies, including foods, medications, plastics, metals, etc.: _____

Please list all medications or provide a list at check-in: _____

Marital Status: _____ Employment/Student Status: _____ Employer/School: _____

Do you currently use recreational drugs? No Yes – What drugs? _____ How often? _____

Do you currently drink alcoholic beverages? No Yes – How often? _____

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months?

No Yes – How often have you used a tobacco product in the past 24 months?

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

Do you use a cellphone or other mobile device? No Yes If yes, please list type (iOS (Apple®), Android™, etc.):_____

Signature below indicates that all information listed here is correct and up to date.

Signature: _____ Date: _____

Relationship if not signed by patient (e.g., guardian, POA, etc.): _____