1305 East Stroop Rd
Kettering, OH 45429

South Dayton **Hearing Aids & Audiology**
Your Path to Better Hearing

ADULT CASE HISTORY

Patient Name: _____ **Age:** _____ **Date:** _____

1. Main Concern:

- ○ HEARING LOSS ___RIGHT EAR ___LEFT EAR
- ○ DIFFICULTY HEARING ___IN QUIET ___ IN NOISE
- ○ TINNITUS/RINGING
- ○ TELEPHONE___RIGHT EAR ___ LEFT EAR
- ○ DIZZINESS

2. How long have you noticed this difficulty? _____

3. Is the difficulty due to a work-related injury/exposure?

(Y) (N) IF SO. DATE OF INJURY: _____ EXPLAIN: _____

4. Do you feel your hearing is changing?

(Y) (N) ○ GRADUAL ○ SUDDEN

5. Have you been exposed to loud noise, either recently or in the past?

(Y) (N)
- ○ FARM MACHINERY
- ○ POWER TOOLS
- ○ MUSIC
- ○ MILITARY
- ○ HUNTING/SHOOTING
- ○ JET ENGINES
- ○ FACTORY NOISE
- ○ OTHER _____

6. Have you seen an Ear, Nose and Throat Physician?

(Y) (N) IF SO: WHEN WAS YOUR LAST VISIT: _____ NAME OF PHYSICIAN _____

7. Have you ever had surgery that may have affected your hearing?

(Y) (N)

8. Is there a history of hearing loss in your family?

(Y) (N) IS SO: WHO? _____

9. Do you have a Pacemaker?

(Y) (N)

10. Have you ever had an ear infection?

(Y) (N) ○ AS A CHILD ○ AS AN ADULT

11. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?

(Y) (N) IF YES, PLEASE DESCRIBE: _____

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12. Do you take any prescription medications on a regular basis? Please List below:

_____

_____

_____

_____

13. Do you take any Aspirin or any blood thinners?

(Y) (N) IF YES, NAME OF MEDICATION _____ HOW OFTEN _____

14. Please check any of the following that you currently have or have had in the past:

- ○ ARTHRITIS
- ○ ASTHMA
- ○ HIGH BLOOD PRESSURE
- ○ NEUROLOGICAL SYMPTOMS
- ○ HEART TROUBLE
- ○ HEPATITIS
- ○ SINUSITIS
- ○ STROKE/TIA
- ○ MEASLES
- ○ MENINGITIS
- ○ DIABETES
- ○ HEAD INJURY
- ○ PARKINSON'S
- ○ BELL'S PALSY
- ○ HIV
- ○ LOSS OF SIGHT
- ○ CANCER _____ TYPE
  - (Y) (N) RADIATION
  - (Y) (N) CHEMOTHERAPY
- ○ OTHER _____

15. Please rank the following in order of importance [1-4], if a hearing aid is recommended for you:

____ IMPROVED HEARING IN QUIET

____ IMPROVED HEARING IN NOISE

____ AFFORD-ABILITY

____ COSMETIC APPEARANCE

16. If you are currently using a hearing aid, or have in the past, please answer the following:

a. Which ear was aided? (L) (R)

b. How long have you used a hearing aid? _____

c. What would improve your current aid? _____

_____

_____

South Dayton Hearing Aids & Audiology

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Hearing Device History and Needs Assessment

1. What was your primary motivation for visiting us today?

2. Hearing device history

- ○ I have a hearing device and use it often in both ears.
- ○ I have a hearing device and use it often in the right ear.
- ○ I have a hearing device and use it often in the left ear.
- ○ I have a hearing device, but don't use it, or rarely use it.
- ○ I tried a hearing device, but returned it.
- ○ I have inquired about devices elsewhere, but did not purchase.
- ○ I have never used a hearing device.

3. If we find out hearing instruments can help you, how would you rank these four items from most important to least important in your purchasing decision? 1 = most important ..... 10 = least important

☐ Sound Quality ☐ Durability/Reliability ☐ Cost ☐ Appearance

4. On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially) regarding moving forward about your hearing impairment? (1 = not ready ..... 10 = ready)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Please list situations where you have difficulty hearing or communicating. Be as specific as you can, as this will help us find the right solution for your specific needs. Try to include your spouse if at all possible.

Example: I have difficulty understanding my companion when sitting across the table in a moderately noisy restaurant.

Please rank these environments from the most frustrating to the least in order one through four.

1. _____

2. _____

3. _____

4. _____