



## 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)

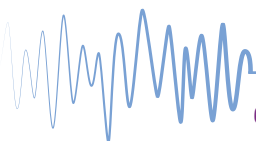
How long have you noticed this difficulty? \_\_\_\_\_

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: \_\_\_\_\_



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.): \_\_\_\_\_