Rehder Balance & Hearing Clinic, Inc.

1101 N. 27th Street, Suite E
Billings, MT 59101

Phone: (406) 245-6893 or (800) 227-3181
Fax: (406) 245-9954

Adult Case History

Patient Name: _____ **DOB** _____ **Date**: _____

Please answer these questions to the best of your ability. Having this information is helpful to us in understanding your hearing problem and determining the best solution for your hearing needs.

How did you hear about us? (Check all that apply)

- ❑ Friend, word of mouth, relative. Who? _____
- ❑ Physician referral. Who? _____
- ❑ Other: _____
- ❑ TV
- ❑ Yellow pages
- ❑ Letter of invitation
- ❑ Newspaper
- ❑ Website
- ❑ Newsletter

★**For what reason was this hearing test scheduled? Please explain**. _____

Required Screening Data:

- **Do you use any form of tobacco? Yes No**

Hearing Sensitivity:

1. Yes No Do you feel that you are experiencing a hearing problem? Which ear? **Both Right Left**
   If Yes, How long have you been aware of the problem? _____
   Yes No Was the hearing loss…(circle one) **Gradual Sudden**
   If gradual, when did you first notice there was a problem? _____
   If sudden, what were you doing just prior to it getting worse? _____
   Yes No Do you feel one ear is better than the other? If yes, which is your better ear? _____
   Yes No Have you had your hearing tested before?
   If yes, when? _____ Results? _____

Please respond to the following statements (Circle one) **0= Strongly disagree 2=Neutral 4= Strongly agree**					
I have communication difficulties when speaking with one person (i.e., spouse, store clerk)	**0**	**1**	**2**	**3**	**4**
I have communication difficulties when speaking in small groups (i.e., dinner party, playing cards)	**0**	**1**	**2**	**3**	**4**
I have communication difficulties when in a large group (i.e., church, clubs, meeting, lectures)	**0**	**1**	**2**	**3**	**4**
I have communication difficulties with various types of entertainment (i.e., movies, TV, theatre)	**0**	**1**	**2**	**3**	**4**
I have communication difficulties in noisy environments (i.e., riding in a car, restaurants, parties)	**0**	**1**	**2**	**3**	**4**
I feel my hearing limits my personal life.	**0**	**1**	**2**	**3**	**4**
My hearing difficulties upset me.	**0**	**1**	**2**	**3**	**4**
Other people have suggested you have a hearing problem.	**0**	**1**	**2**	**3**	**4**

★**Rate your overall hearing ability**: (Circle one)

"**No Problems at all**" **0 1 2 3 4 5 6 7 8 9 10** "**Extreme difficulty**"

Otologic History

1. Yes No Have you seen an Ear, Nose and Throat Physician?
   If yes, who did you see? _____ When? _____
2. Yes No Do you have pain or discomfort in your ear? Which ear? **Both Right Left**
3. Yes No Have you ever had an ear infection? If yes, (Circle) **As a child As an adult**
4. Yes No Have you had any recent drainage from your ears? **Both Right Left**
5. Yes No Have you taken medication for an ear problem? What? _____ When? _____
6. Yes No Have you ever had ear surgery? **Both Right Left**
   If yes, please describe. _____
7. Yes No Do you have feelings of pressure or fullness in your ears? **Both Right Left** When? _____
8. Yes No Have you ever had a severe injury to your head? When? _____
9. Yes No Have you ever had a perforated eardrum? **Both Right Left** When? _____
10. Yes No Is there a family history of hearing loss? If so, who? _____
    If yes, do you know the cause of their hearing loss? _____
11. Yes No Have you ever been exposed to high levels of noise? If yes, check all that apply. ❑ farm equipment ❑ power tools ❑ lawn mowers ❑firearms ❑occupational noise ❑ Music ❑ Military ❑ Other _____
    If yes, did you use hearing protection? **Yes No Sometimes**

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Patient Signature _____

Tinnitus

1. Yes No Do you have noises in your ears? **If no, go to 6**, If yes, **Both Right Left**
   Please describe it. _____
   When did you become aware of your tinnitus? _____
   How bad is it?(Circle one) **Non-bothersome A little bothersome Bothersome Very bothersome**
2. Yes No Is the noise constant?
3. Yes No Does the noise fluctuate?
4. Yes No Does the noise keep you from falling asleep at night?
5. Yes No I have received treatments for my tinnitus? If yes, what and was it successful? _____
6. Yes No Do you have TMJ, jaw pain or grinding and clicking sensations in your jaw?

Dizziness /Imbalance

1. Yes No Have you experienced dizziness or loss of balance in the last 90 days? **If no, go to next section**. If yes, do you know the cause? What? _____
2. Yes No I feel off balance when I'm dizzy.
3. Yes No I feel lightheaded when I'm dizzy
4. Yes No I feel a spinning sensation when I am dizzy.
   My dizziness / loss of balance is…(Circle one) **Constant Comes and goes**
   If it comes and goes, how long does the feeling last? **Seconds Minutes Hours Days**
5. Yes No I become dizzy when I change position (bending, rolling in bed, looking up)

Medical History

Yes	No	Heart or circlation problems	Yes	No	Heart attack. When? _____
Yes	No	High blood pressure	Yes	No	Cardiac Surgery. When? _____
Yes	No	Stroke	Yes	No	Blood thinners
Yes	No	TIAs	Yes	No	Multiple sclerosis
Yes	No	Hepatitis	Yes	No	Siezures
Yes	No	Diabetes	Yes	No	Meningitis
Yes	No	Headaches	Yes	No	IV antibiotics for a life threatening infection.
Yes	No	Migraines	Yes	No	Erectile dysfuction medication
Yes	No	Head trauma. When? _____	Yes	No	Cancer. What type? _____
Yes	No	Arthritis	Yes	No	Cancer treatment. (Radiation, chemotherapy)
Yes	No	Sinusitis	Yes	No	Anxiety or Depression
Yes	No	Bell's Palsy	Yes	No	Dementia or Alzheimers
Yes	No	Meniere's	Yes	No	Other _____

Medications: Please list all your current medications, including hormones, birth control pills, vitamins, over-the-counter, etc. Please include the name of the medication, dosage and times per day taken.

Name	Dosage	# Times per day

Hearing aid History

1. Yes No I am currently wearing a hearing aid or have in the past. **If no go to 2**. If yes,
   Which ear is aided?(Circle one) **Both Right Left**
   How long have you used a hearing aid? _____ What kind is it? _____
   What would improve your current aid? _____
2. Yes No It is very important for me to improve my hearing.
3. Yes No I am motivated to wear and use hearing aids if they are recommended If yes, Please rank the following in order of importance 1-4 (1 as the most important and 4 as the least important)
   _____ Improved hearing in quiet _____ Improved hearing in noise
   _____ Cosmetic appearance _____ Expense

Thank you for taking the time to fully complete this questionnaire. Remember to bring it with you to your appointment