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**: _____

How did you hear about us?

Friend, word of mouth, relative. Who? _____ Physician referral. Who? _____

Other: _____

Presenting Problem

1. What is your primary complaint about your ears or hearing? _____
2. What do you think caused your hearing problem? _____
3. How long have you been aware of this problem? _____
4. Which is your worse ear (if they are different): Left _____ Right _____
5. Do you have difficulty understanding:

   TV: Yes_____ No_____ Telephone: Yes_____ No_____ In groups: Yes _____No_____

   What listening situations are you experiencing communication difficulties?

   List at least 2 or more: _____

   How does that impact you? _____
6. How important is it for you to improve how you hear, understand, or communicate with others RIGHT NOW (mark on the line)

0 (Not at all important) 10 (Extremely important)

Otologic History

1. Have you had your hearing tested before? Yes_____ No_____ If yes, when and where? _____
2. Any drainage from the ear within the past 90 days? Yes_____ No_____
3. Have you experienced any dizziness, balance problems, or falls in the past 90 days? Yes_____ No_____
4. Have you had any pain/discomfort in your ears within the past 90 days: Yes_____ No_____
5. Have you ever lost hearing in one ear *suddenly*? Yes_____ No_____
6. Do you have any noises or ringing in your ears? Yes_____ No_____ left/right/both

   If present, is it: Constant _____ Intermittent _____ When did you first notice it? _____

   Does it disrupt your normal everyday activities? Yes_____ No_____
7. Have you received any medical or surgical treatment for hearing loss or disease of the ear? Yes_____ No_____

   If yes, please describe: _____
8. Have you ever been exposed to loud noise? Yes_____ No_____

   If yes: _____ Military _____ Occupation/Job _____ Recreational _____ Other: _____

   Did you use ear plugs/muffs? Yes_____ No_____
9. Is there a history of hearing loss in your immediate family? Yes_____ No_____

   If yes, who: _____
10. Do you have trouble with arthritis, stiffness, numbness in your fingers? Yes_____ No_____

Rehder Balance & Hearing Clinic, Inc.

Patient Signature _____

Medical History

Yes	No	High blood pressure	Yes	No	IV antibiotics for a life threatening infection.
Yes	No	Stroke	Yes	No	Cancer. What type? _____
Yes	No	Diabetes	Yes	No	Cancer treatment. (Radiation, chemotherapy)
Yes	No	Migraines	Yes	No	Head trauma. When? _____
Yes	No	Arthritis	Yes	No	Erectile dysfuction medication
Yes	No	Anxiety	Yes	No	Meniere's
Yes	No	Depression	Yes	No	Other _____
Yes	No	Dementia or Alzheimers			_____

Medications: Please list all (use back of paper) 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 or provide a list.

.Are you currently taking Blood thinners? Yes No

Name	Dosage	# Times per day

Hearing aid History

1. Do you wear hearing aids NOW? Yes_____ No_____ When did you get them? _____

   If not, have you ever **tried** hearing aids? Yes_____ No_____

   How would you rate your experience with your hearing aid(s) on a scale of 0 (terrible) to 10 (great)? _____

   If you have never worn/tried a hearing aid, go to 2.

   If so, which ear and what type and make? _____

   How often do you wear your hearing aids? _____

   What do you like best about your hearing aids? _____

   How could your hearing aids be better? _____

   Are you interested in discussing new updated hearing aid technology today? Yes No Maybe
2. How important is it to you to make a change for better communication and why? _____
3. Are you motivated to wear and use hearing aids (if they are recommended) to meet your communication needs?

   _____ **Yes I am motivated** _____ **No I am not motivated** _____ **I'm unsure of my motivation**
4. Are you optimistic that your hearing can be improved with hearing aids? _____
5. What's most important to you in your consideration of hearing aids? **Rank** the following in order of importance 1-4 (1 as the most important and 4 as the least important) _____ Improved hearing in quiet _____ Cosmetic appearance _____ Improved hearing in noise _____ Expense
6. Select all that apply:

   _____ I do not think I'm ready for hearing aids at this time.

   _____ I have been thinking that I might need hearing aids.

   _____ I have started to seek information about hearing aids.

   _____ I am comfortable with the idea of wearing hearing aids.

   _____ I am ready to wear hearing aids if they are recommended.

   _____ I currently wear hearing aids.

- Are there any specific questions you would like answered today? _____