

Rehder Balance & Hearing Clinic, Inc.

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Adult Case History

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

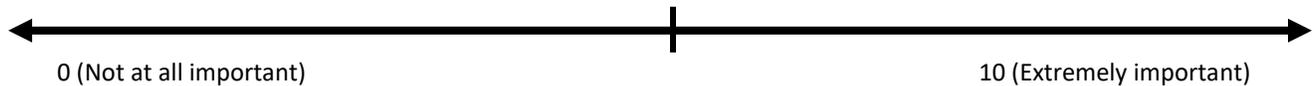
How did you hear about us?

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)



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 _____

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 dysfunction 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

- 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
- How important is it to you to make a change for better communication and why? _____
- 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**
- Are you optimistic that your hearing can be improved with hearing aids? _____
- 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 _____
- 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? _____