Rehder Balance & Hearing Clinic

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Fax:

Adult Case History

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

How did you hear about us? _____
(i.e. Friend, relative, word of mouth, physician, Internet, other)

Presenting Problem

1. What is the primary reason you came in today? [] Hearing Loss [] Tinnitus [] Dizziness/Vertigo [] Other
2. What do you think caused the problem? _____
3. How long have you been aware of this problem? [] < 1 month [] 2-12 months [] 1-7 years [] 7+ years
4. Which is your worse ear (if they are different): [] Left [] Right [] Same
5. Which of the following listening situations are challenging due to your problem: (check all that apply):
   [] TV [] Telephone [] Groups [] Family members [] Restaurants
   [] Speech in background noise [] Plays/Concerts [] Meetings [] Worship service
6. How important is it to improve how you hear, understand, or communicate with others RIGHT NOW (circle one)
   Not at all important Somewhat important Extremely important

Otologic History

1. Have you had your hearing tested before? [] Yes [] No If yes, when and where? _____
2. Do you currently have or had any of the following in the past 6 months:
   [] Ear pain [] Ear pressure [] Dizziness/Vertigo [] Excessive ear wax
   [] Ear drainage [] Ear infection [] Balance issues or falls [] Swimmer's Ear
3. Have you ever lost hearing in one ear *suddenly*? [] Yes [] No If yes, when? _____
4. Do you have any noises or ringing in your ears? [] Yes [] No If yes, left/right/both (circle)
   When did you first notice it? _____ What does it sound like? _____
   Does it disrupt your normal everyday activities? [] Yes [] No If yes, how? _____

_____

5. Have you received any medical or surgical treatment for hearing loss or ear disease? [] Yes [] No
If yes, please describe: _____
6. Have you ever been exposed to loud noise? [] Yes [] No
   Check all that apply: [] Military [] Occupation [] Recreational [] Other: _____
7. Is there a history of hearing loss in your immediate family? [] Yes [] No If Yes, who?

_____

8. Do you have trouble with arthritis, stiffness, numbness in your fingers? [] Yes [] No

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Hearing Aid History

1. Do you wear hearing aids NOW? [] Yes [] No
   If yes, when did you get them? _____ Brand and model of hearing technology: _____
2. If "no," have you ever **tried** hearing aids? [] Yes [] No If yes, where? _____

If you answered "No" to question 1 and 2 – skip to question 8

3. How often is your hearing technology meeting your lifestyle and listening needs:
4. How would you rate your overall experience with hearing aid(s): (circle one) Terrible Mediocre Good Great
5. What do you like best about your hearing aids?_____
6. How could your hearing aids be better?
_____
7. Are you interested in discussing new updated hearing aid technology today? [] Yes [] No [] Maybe
8. Select all that apply: [] I do not think I am ready for hearing aids currently.
[] 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.
9. Describe your current **LISTENING** lifestyle:
[] Dynamic (frequent background noise) [] Quiet (limited background noise)
[] Active (occasional background noise) [] Private (rare background noise)
8. Are you optimistic that your hearing can be improved with hearing aids?_____
9. What's most important to you in your consideration of hearing aids?
Rank the following in order of importance 1-5 (1 as the most important and 5 as the least important)
___ Hearing in quiet ___ Cosmetics ___ Hearing in noise ___Expense ___ Easy to use
10. Do you use a smart phone? [] Yes [] No If yes, what kind?
_____
11. Are there any specific questions you would like answered today?
_____

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	Dementia or Alzheimers	[] Yes	[] No	Meniere's
[] Yes	[] No	Anxiety	[] Yes	[] No	TMJ (jaw joint dysfunction)
[] Yes	[] No	Depression	[] Yes	[] No	Other_____

[] Yes [] No Are you currently taking Blood thinners?

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.