Memphis Speech and Hearing Center
Audiology Adult Case History

HISTORY:
Describe the problems you are having with your hearing or balance: ________________________________________________

When did you (or others) first notice the problem? ___________________________________________________________

Have you had your hearing tested recently?  □ Yes  □ No

PHYSICAL HISTORY:
Do you wear glasses/contacts?  □ No  □ Glasses  □ Contacts  □ Both
Please describe past illness/injury/hospitalization information below including the date of the illness, a description of the illness, and whether or not it required hospitalization: ___________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Have you ever been diagnosed with memory problems?  □ Yes  □ No

ALLERGIES:
Please list all allergies below (medications, Latex, food, environmental, etc.) __________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

MEDICATIONS:
Have you ever taken medicine that may harm your hearing?  □ Yes  □ No
Please list all medications (prescribed and over the counter) that you are currently taking on a regular basis. Include the medication’s name, dosage, how often it’s taken, and the route of administration. __________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

If additional space is needed to list all medications, please notify staff for an additional form.

HEARING HISTORY:
Have you had a hearing test? If yes, in which ear? □ Right  □ Left  □ Both
When was the hearing test? __________________________________________________________
What were the results of the hearing test? _____________________________________________
Which ear(s) do you have problems hearing? □ Right  □ Left  □ Both
Has your hearing loss been? □ Gradual  □ Sudden  □ Fluctuating
Has a hearing aid ever been recommended for you? □ Yes  □ No
Do you wear a hearing aid? □ Yes  □ No
Which ear? □ Right  □ Left  □ Both
In what ways does your hearing loss affect your daily life? _____________________________________________
____________________________________________________________________________________________________

If yes, for how long?  ____________________________________________________________
Type of hearing aid: ____________________________________________________________

Has anyone in your family had a hearing loss?  □ Yes  □ No

Do you have difficulty hearing in the situations listed below?
On the telephone □ Yes  □ No  Children talking □ Yes  □ No
Watching television □ Yes  □ No  Men talking □ Yes  □ No
At restaurants □ Yes  □ No  Women talking □ Yes  □ No
One-on-one at home  □ Yes  □ No  At Church  □ Yes  □ No  
Group situations  □ Yes  □ No
Have you ever been treated for ear infections?  □ Yes  □ No  If yes, when? ________________________  
Have you ever been diagnosed with an ear disorder or had ear surgery?  □ Yes  □ No  
Please explain:
Do you have any noises in your ears?  If yes, in which ear?  □ Right  □ Left  □ Both  
Do you have episodes of dizziness?  □ Yes  □ No  
Do you have any pain or fullness in your ears?  □ Yes  □ No  
Have you ever been exposed to loud noises?  □ Yes  □ No  
Please indicate those noises you have been exposed to:  
□ Gunfire  □ Explosions  □ Factory Noise  □ Power Tools  □ Motorcycle  □ Aircraft 
□ Power Mower  □ Loud Music  □ Military Service  □ Heavy Equipment  □ Other  
Have you ever worn, or do you currently use hearing protection?  □ Yes  □ No  
Please add any other concerns you may have that have not been addressed:  

INTERPRETIVE SERVICES:
Client preferred language  □ English  □ Spanish  □ Vietnamese  □ Arabic  □ Mandarin  □ Other 
□ American Sign Language  □ Communication Assistive Devices  □ Mandarin  □ Unknown  
Person with client preferred language  □ English  □ Spanish  □ Vietnamese  □ Arabic  □ Mandarin  □ Other 
□ American Sign Language  □ Communication Assistive Devices  □ Mandarin  □ Unknown  
□ No primary caregiver identified

SOCIAL HISTORY:  *these questions must be addressed for patients 10 years old or older.  
History of tobacco use:  □ Never smoked  □ Former smoker (circle ceased smoking in last 30 days or >30 days)  
□ Current every-day smoker  □ Current some day smoker  □ Heavy tobacco smoker  □ Light tobacco smoker 
□ Secondhand smoke exposure  □ Type of tobacco  □ Packs per day ________  
Have you abused substances in the past 30 days?  □ Yes  □ No  
If yes, type of substance:  □ Heroin  □ Inhalants  □ Marijuana  □ Methamphetamine  □ Narcotics  
□ Sedatives  □ Cocaine  □ Ecstasy  □ Hallucinogenic  □ Ketamine  □ Other  
Substance amount ______________  Date of last use: ___ / _____ / _____  
Alcohol use/frequency  □ None  □ <12 drinks/week  □ 12+ drinks/week  □ 5+ drinks per occasion once/week  
Alcohol amount ______________  When was your last drink? ______________  

Person completing this form: __________________________________________________