

CASE HISTORY

Date _____
Name _____ DOB _____ Age _____ M _____ F _____
Address/City/State/Zip _____
Home Phone _____ Work Phone _____
Person responsible for payment _____
How did you know to come to this office? _____
Doctor/Phone # _____
Insurance _____
 Phone # _____ Group # _____
 Insured's Name _____ DOB _____
 SS# or ID# _____ Spoke with _____
 Benefits _____
Services needed _____

HEARING HISTORY

Have you had your hearing tested before? _____
When did you first notice you had a hearing problem? _____
What do you think caused your hearing loss? _____
Has your hearing loss gradually progressed or did it become worse all of a sudden? _____
Do you or have you ever experienced any of the following:
 _____ Ringing _____ Excess Ear Wax _____ Meningitis
 _____ Dizziness _____ Ear Surgery _____ Diabetes
 _____ Nausea _____ Difficulty Understanding _____ Exposure To Loud Noise
 _____ Sinus Problems _____ Speech/Language Development Problems _____ Guns
 _____ Allergies _____ Frequent Colds _____ Work Related Noise
 _____ Earaches _____ Sudden Hearing Loss _____ Loud Music
 _____ Ear Infections
Treatment for the above _____

Do other members of your family have hearing problems? _____
Who is your Ear/Nose/Throat doctor? _____
Who is your family physician? _____
If patient is a child:
Are they developing speech/language normally? _____
Are they experiencing difficulty in school? _____
What subjects? _____ What school/teacher? _____
Are they doing most things as soon as others their age? _____

MEDICAL HISTORY

Status of Health _____
Surgeries _____
Ear Infections _____ Ear Surgeries _____
List of medications _____
