ALBUQUERQUE
HEARING AND BALANCE

ADULT CASE HISTORY

(Please Print)

Patient Name____Age_______________Today's Date __________________

Chief complaint

☐ Hearing Loss ☐ Right ear ☐ Left ear ☐ Tinnitus/Ringing ☐ Dizziness

☐ Difficulty hearing ☐ in Quiet ☐ in Noise ☐ Telephone ☐ Right ear ☐ Left ear

How long have you noticed this difficulty? ______________________________________

Is this problem due to a work-related injury/exposure? ☐ Yes ☐ No

If so: Date of Injury________________________Explain____

Do you feel your hearing is changing? ☐ Yes ☐ No If yes, ☐ Gradual ☐ Sudden

Have you ever been exposed to loud noises, either recently, or in the past? ☐ Yes ☐ No
If so *mark those that apply*

☐ Farm Machinery ☐ Music ☐ Hunting/Shooting ☐ Factory Noise

☐ Power Tools ☐ Military ☐ Jet Engines ☐ Other_____________________________

Have you seen (or will be seeing) an Ear, Nose and Throat Physician? ☐ Yes ☐ No

If so, who?____When?____

Have you ever had surgery that may have affected your hearing? ☐ Yes ☐ No

Is there a history of hearing loss in your family? ☐ Yes ☐ No If so, who?______________________________________

Have you ever had an ear infection? ☐ Yes ☐ No If yes, ☐ as a child ☐ as an adult

Do you have a history of temporomandibular joint dysfunction (TMJ disorder)? ☐ Yes ☐ No

In the past 10 years have you experienced chronic or acute dizziness, light-headedness, or vertigo? ☐ Yes ☐ No

If yes, please describe ____

Do you take any prescription medications? Please list (or attach): ***REQUIRED FOR MEDICARE PATIENTS***

Medication____Form_____ Frequency_____ Dose_____________

Medication____Form_____ Frequency_____ Dose_____________

Medication____Form_____ Frequency_____ Dose_____________

Please check any of the following that you currently have or have had in the past:

☐ Arthritis	☐ Heart Trouble	☐ Measles	☐ Parkinson's
☐ Asthma	☐ Hepatitis	☐ Meningitis	☐ Scarlet Fever
☐ Bell's Palsy	☐ High Blood Pressure	☐ Mumps	☐ Sinusitis
☐ Diabetes	☐ HIV	☐ Neurological Symptoms	☐ Stroke/TIA
☐ Head Injury	☐ Malaria	☐ Visual Trouble	☐ Cancer

If you are currently using hearing aids, or have in the past, please answer the following:
Which ear is/was aided? ☐ Right ☐ Left How long have you used hearing aids?______________________________

***MEDICARE PATIENTS ONLY**: Have you been a smoker in the past 2 years?* ______

leave blank for administrative use