# Case History

Patient Name________________________________________Date of Birth _______________
Date:____________________

**Please complete the following questions.**

| Yes | No | |
|---|---|---|
| _____ | _____ | Do you feel you are hard of hearing? If so, which ear? _____ For how long? _____ Is the problem becoming worse? _____ |
| _____ | _____ | Do you have trouble understanding people when they talk? |
| _____ | _____ | Have you recently experienced pain or drainage in your ears? |
| _____ | _____ | Do you have ringing in your ears? If yes, which ear (or both)? _____ |
| _____ | _____ | Do your ears feel plugged? If yes, which ear? _____ |
| _____ | _____ | Do you ever have dizzy spells? If yes, when was the last one? _____ |
| _____ | _____ | Have you ever had an operation on your ears? If yes, when, which ear, and what type of surgery?________________________ |
| _____ | _____ | Have you ever had a doctor remove wax from your ears? |
| _____ | _____ | Is there a family history of hearing loss? If yes, who? _________ |
| _____ | _____ | Have you ever been exposed to loud noise (such as, factory work, military, motorcycles, snowmobiles, gunshots or farm machinery)? If yes, did you wear hearing protection? _______ |
| _____ | _____ | Have you ever worn a hearing aid? |
| _____ | _____ | Do you have any vision problems? |

Medication list

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

**Have you had any of the following**

| Yes | No | | |
|---|---|---|---|
| _____ | _____ | Meningitis | When? __________ |
| _____ | _____ | Scarlet fever | __________ |
| _____ | _____ | Mumps | __________ |

## Case History

| Yes | No | | |
|---|---|---|---|
| _____ | _____ | Measles | __________ |
| _____ | _____ | Tuberculosis (TB) | __________ |
| _____ | _____ | Hepatitis (A,B, or C) | __________ |
| _____ | _____ | Syphilis | __________ |
| _____ | _____ | Diabetes | __________ |
| _____ | _____ | Multiple Sclerosis | __________ |
| _____ | _____ | Concussion or loss of consciousness | __________ |
| _____ | _____ | Kidney disease | __________ |
| _____ | _____ | Immune disorders | __________ |
| _____ | _____ | Heart disease | __________ |
| _____ | _____ | Allergies | __________ |
| _____ | _____ | Seizures | __________ |

Other recent medical/surgical history

"I have completed this information accurately and to the best of my knowledge."

Patient Signature & Date ____________________________________________________

Name of person completing this form & relationship to patient ____________________
__________________________________________________________________________

# Case History

**Complete the remainder of this form only if the patient is a child**

Birthing hospital___________________________________________________________

Did the child pass the newborn hearing screening at the hospital?_______________

Length of pregnancy___________________________Birth weight___________________

Any complications during or following the birth?_______________________________

How long was the baby in the hospital?_____________________________________

Was the baby given any medication?_______________________________________

Was the baby placed on any monitoring equipment?___________________________

Any maternal drug/alcohol use?___________________________________________

Did any of the following occur during the pregnancy, herpes, rubella, syphilis, toxoplasmosis, cytomegalovirus (CMV)? (If so, describe treatment) _______________

Is the child in daycare/preschool?_________________________________________

Has the child been diagnosed with any syndrome or permanent medical condition, if so please describe ______________________________________________________

_____________________________________________________________________

Has the child been hospitalized since birth (please describe) ____________________

_____________________________________________________________________

Approximately what age did the child say his/her first word? ____________________

Approximately what age did the child speak in three word sentences? ____________

How does the child express his/her needs? _________________________________

Does the child use sign language? ________________________________________

Does the child look when his/her name is called?_____________________________

Explain why you are concerned about the child's hearing ______________________

Please provide any additional information you feel might be important in working with this child ___________________________________________________________

Patient name ___________________________Signature__________________________