ELITE HEARING & BALANCE

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ADULT CASE HISTORY

PATIENT INFORMATION

Patient name: _____ Date of birth: _____

Referring provider: _____ Primary care provider: _____

REASON FOR TODAY'S VISIT

Please describe your main concern:

_____

_____

HEARING HISTORY

Do you feel that you have difficulty hearing? ☐ Yes ☐ No ☐ Unsure

If yes, affected ear(s): ☐ Right ☐ Left ☐ Both

When did you notice the hearing difficulty? _____

Did the hearing difficulty begin: ☐ Suddenly ☐ Gradually ☐ Unsure

Over time, has your hearing: ☐ Stayed the same ☐ Worsened ☐ Fluctuated

Have you had a hearing test before? ☐ Yes ☐ No

Do you currently use or have you previously used hearing aids? ☐ Yes ☐ No

If yes, how satisfied are you with your current or previous hearing aids?

☐ Satisfied ☐ Somewhat satisfied ☐ Not satisfied

OTOLOGIC HISTORY

Do you currently experience any of the following:

Ear pain or discomfort: ☐ Right ☐ Left ☐ Both

Pressure or fullness: ☐ Right ☐ Left ☐ Both

Ear drainage or discharge: ☐ Right ☐ Left ☐ Both

Do you have any of the following? Please select all that apply:

☐ Recurrent ear infections ☐ Family history of hearing loss

☐ History of ear surgery ☐ History of significant noise exposure

☐ History of ear or head trauma ☒ Diagnosed ear disorder, describe: _____

TINNITUS

Do you experience tinnitus? ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both ☐ In the head

Character: ☐ Ringing ☐ Buzzing ☐ Hissing ☐ Other: _____

Is your tinnitus: ☐ Constant ☐ Intermittent

BALANCE AND DIZZINESS

Do you experience dizziness, vertigo, or imbalance? ☐ Yes ☐ No

If yes, how would you describe it? ☐ Spinning ☐ Lightheaded ☐ Unsteady or off balance

How long does a typical episode last? _____

Are your symptoms triggered by head movement or changes in position? ☐ Yes ☐ No

Have you fallen because of dizziness or imbalance? ☐ Yes ☐ No

HEARING AND COMMUNICATION NEEDS

In which situations do you have difficulty hearing or understanding speech? *Select all that apply.*

☐ One-on-one conversations
☐ Group conversations
☐ Restaurants or other noisy places
☐ Watching television
☐ Other: _____
☐ Telephone or video calls
☐ Meetings, classes, or religious services
☐ Understanding soft voices
☐ Women's or children's voices
☐ I do not notice any communication difficulty

Do you ask others to repeat themselves?
☐ Often ☐ Sometimes ☐ Never

Do you feel frustrated during conversations because difficulty hearing?
☐ Often ☐ Sometimes ☐ Never

Do you avoid or participate less in social activities because of difficulty hearing?
☐ Often ☐ Sometimes ☐ Never

Does your hearing difficulty affect your work, relationships, safety, or daily activities?
☐ Yes ☐ No If yes, please explain: _____

What would you most like to improve about your hearing or communication?

_____

_____

_____

MEDICAL HISTORY

Please select all that apply:

☐ Diabetes	☐ Thyroid disorder	☐ Autoimmune disorder
☐ High blood pressure	☐ Low blood pressure	☐ HIV/AIDS
☐ Alzheimer's / dementia	☐ Anemia/blood disorder	☐ TMJ disorder
☐ ADD/ADHD	☐ Anxiety or panic attacks	☐ Depression
☐ Genetic disorder/syndrome	☐ Kidney disease	☐ Chronic pain
☐ Herpes or shingles	☐ History of high fever	☐ Liver disease
☐ Multiple sclerosis	☐ Neuropathy	☐ Ménière's disease
☐ Syphilis	☐ Tuberculosis	☐ Otosclerosis
☐ Cardiovascular disease	☐ High cholesterol	☐ Abnormal heart rhythm
☐ Hepatitis	☐ Mumps	☐ Stroke or TIA
☐ Rubella	☐ Arthritis	☐ Meningitis or encephalitis
☐ Migraine or frequent headaches	☐ Head injury or concussion	☐ Measles
☐ Parkinson's disease or tremor	☐ Seizures or convulsions	☐ Cancer
☐ Radiation to the head or neck	☐ Allergy/sinus problems	☐ Chemotherapy

☐ Glaucoma, cataracts, or macular degeneration

☐ Other: _____

Have you had any major surgeries or hospitalizations? ☐ Yes ☐ No

If yes, please describe: _____

_____

Please list your current medications:

_____

_____