AMERICAN HEARING CENTER

Adult Case History

Name: ____ Date: _______________
Last First Middle Initial

Date of birth: ______________________ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Widowed

Name of Spouse: _______________________________________

What is your primary language? ______________________

How did you find out about us? (Check all that apply)

☐ Facebook	☐ Family or Friend	☐ Instagram	☐ Insurance List	☐ Mail Out
☐ Newspaper	☐ Physician Referral	☐ Radio	☐ Saw Sign	☐ TV
☐ Yellow Pages	☐ Website	☐ Youtube	☐ _______________	

Has a medical professional diagnosed you with a hearing loss? ☐ Yes ☐ No

Do you or a family member suspect you have a hearing loss? ☐ Yes ☐ No
If yes, please explain ____

Is your hearing better in one ear? ☐ No ☐ Right ☐ Left

*Have you had a sudden change in your hearing? ☐ Yes ☐ No
If yes, please explain ____

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

Have you ever had surgery or illness that may have affected your hearing? ☐ Yes ☐ No
If yes, please explain ____

*Do you have any tinnitus (ringing or noises in your head)? ☐ No ☐ Right ☐ Left ☐ Both

*Do you consider dizziness to be a problem for you? ☐ Yes ☐ No
If yes, please explain ____

*Have you had recent drainage from your ear(s)? ☐ No ☐ Right ☐ Left ☐ Both

*Do you have pain or discomfort in your ear(s)? ☐ No ☐ Right ☐ Left ☐ Both

Have you seen an Ear, Nose, and Throat (ENT) physician for any of the above conditions? ☐ Yes ☐ No
If yes, when ____

Have you ever been exposed to loud noise either recently or in the past? ☐ Yes ☐ No

☐ Farm Machinery	☐ Music	☐ Hunting/Shooting	☐ Factory Noise
☐ Power Tools	☐ Military	☐ Jet Engines	☐ _______________

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

☐ Arthritis	☐ Heart Trouble	☐ Meningitis	☐ Scarlet Fever
☐ Asthma	☐ Hepatitis	☐ Mumps	☐ Stroke/TIA
☐ Bell's palsy	☐ High Blood Pressure	☐ Neurological	☐ Visual Trouble
☐ Head Injury	☐ Measles	☐ Chemo/Radiation	☐ Parkinson's

Do you have an idea of what hearing aids cost? ☐ Yes ☐ No

Do you have a hearing aid budget in mind? ☐ Yes ☐ No Budget: ___________

Please identify five specific listening situations in which you would like to hear better:

Conversation with my ______________________________ in quiet

Conversation with my ______________________________ in a noisy environment

My favorite television shows _________________________________ and _____________________________

Familiar speaker on the phone

Unfamiliar speaker on the phone

Church or Meeting

In traffic

When someone is at the front door

Other: ____

Please check any statement you feel may apply:

- ☐ My hearing loss causes me to feel embarrassed
- ☐ If I could hear better it would increase my social contact
- ☐ My hearing loss causes me to feel upset or angry
- ☐ My hearing loss causes me to feel left out
- ☐ My hearing loss is affecting my relationships with my family

What is your most important consideration regarding hearing devices? Please Rank in order.

________ Hearing device size and the ability of others not to see the hearing device.

________ Improved ability to hear and understand speech

________ Cost of hearing devices

Please check the statement you feel you best relate to? (Please check one)

- ☐ I don’t think I have a hearing loss.
- ☐ I have some difficulties with my hearing but it does not affect my everyday life.
- ☐ I have a hearing loss; I have started to consider doing something to improve it.
- ☐ I have a hearing loss; it is disturbing and I would like to do something about it.
- ☐ I have a hearing loss and I am actively doing something to improve it.

If you are currently using hearing aid(s) or have in the past, please answer the following:

Which ear(s) were (are) aided? ☐Right ☐Left ☐Both

How long have you used hearing aids? ______________

Have you been successful in wearing hearing aids? Explain ___________________________________

What would improve your current hearing aid(s)? ____