CENTRAL ILLINOIS HEARING, LTD.
ADULT CASE HISTORY

Name _____ **Age:** _____ **Birthdate:** _____

Referred by: _____

- Primary complaint: _____
- Do you have hearing problems? Yes _____ No _____

  Which ear? Right _____ Left _____ Both _____

  Has the hearing loss been Gradual? _____ Sudden? _____ Fluctuating ? _____

  Do you presently use a hearing device? Yes ____ No ____ For how long? _____

  Are you interested in using a hearing device? Yes _____ No _____
- Do you hear noises in your ears or head? Yes _____ No _____
  Which ear? Right _____ Left _____ Both _____
  How often do you hear noises? Constantly _____ Occasionally _____ Rarely _____
- Do you ever have a feeling of fullness or stuffiness in yours ears? Yes _____ No _____
- Do you ever experience facial numbness, weakness or tingling? Yes _____ No _____
- Are you ever dizzy, unsteady or off-balance? Yes _____ No _____

  Is your dizziness accompanied by Nausea? Yes _____ No _____
  Vomiting Yes _____ No _____
  Noises in your ears? Yes _____ No _____
- Have you ever had ear surgery? Yes _____ No _____
  Describe _____
- Have you ever been exposed to loud noises? Yes _____ No _____
  Describe _____ How recently? _____
- Does anyone in your family have a hearing problem? Yes _____ No _____
- Are you currently taking any medication? Yes _____ No ____
  Please list or provide attachment _____
  _____
- Are you taking blood thinners? Yes _____ No _____
- Are you diabetic? Yes _____ No _____

Date: _____ **Signature** _____

(Revised 8/30/16)