UF Speech and Hearing Clinic

435 Dauer Hall, Gainesville, FL 32608

ADULT AUDIOLOGIC CASE HISTORY

Name: ________________________ Date of Birth: _______________Age: ________

Address: ____

City: ___________________________________State: ________ Zip Code: ________

Phone: (H) __________________ (W) _________________Other __________________

Referred by: ____

Occupation: _____________________________Employer: _______________________

Name of person responsible for payment: _____________________________________

Address (if different from above):____

Insurance carrier: __________________________________Policy #: ______________

STATEMENT OF THE PROBLEM

Why did you schedule today's evaluation? ____________________________________

Do you think you have a hearing problem? ______**Yes** ______ **No** _____ **Not sure**

If yes, which ear? _______ **Right** _______ **Left** _______ **Both**

Which do you feel is your better ear? _______ **Right** _______ **Left**

When did you first notice a hearing problem? _________________________________

Has the hearing loss been: _______ **Gradual** _______ **Sudden** _______ **Fluctuating**

Have you had your hearing tested previously? _____**Yes** _____ **No** _____**Not sure**

If yes, where? ______________________________ When? _________________

What were the results? ____

Have you ever consulted an Ear, Nose, and Throat physician? ____**Yes** ____ **No**

If yes, which doctor? ____

What was the reason for your visit? ____

Is there a history of hearing loss in the family? _____ **Yes** _____ **No** ____ **Not sure**

If yes, which family member(s) have a loss? ______________________________

What caused their hearing loss? ____

Check those which apply:

- ☐ Frequent ear infections
- ☐ Draining ears
- ☐ Sudden loss of hearing
- ☐ Ear pain, swelling or tenderness
- ☐ Fullness or pressure in the ears
- ☐ Head, neck or ear surgery
- ☐ Acoustic trauma (gunfire, firecrackers)
- ☐ Frequent colds, allergies/sinus problems
- ☐ Headaches
- ☐ Visual problems
- ☐ Heart trouble
- ☐ Blood pressure problems
- ☐ Diabetes
- ☐ Skull trauma/loss of consciousness

Please indicate which of the following you have had:

- ☐ Measles
- ☐ Mumps
- ☐ Pneumonia
- ☐ Meningitis
- ☐ TB (Tuberculosis)
- ☐ Cerebral Palsy
- ☐ High Fever
- ☐ Scarlet fever
- ☐ Chicken Pox
- ☐ Shingles
- ☐ Hepatitis B
- ☐ CMV
- ☐ Severe Burns
- ☐ Polio
- ☐ Stroke
- ☐ Herpes
- ☐ RH (-) factor
- ☐ Rubella
- ☐ Malaria
- ☐ Diphtheria
- ☐ Jaundice
- ☐ Epilepsy
- ☐ Speech/language problems
- ☐ Cancer/Describe_____________
- ☐ AIDS (HIV+)
- ☐ Rheumatic fever
- ☐ Bacterial/fungal infection
- ☐ Kidney problems
- ☐ Other/Explain: ________________

____

Please list any medications you take regularly:

____

____

DIZZINESS

Have you had/do you have problems with dizziness? ____ **Yes** ____**No** ___**Not sure**

If yes, please check those that apply and answer the questions below:

- ☐ I feel lightheaded
- ☐ I feel off-balance in space
- ☐ I feel like I'm going to fall
- ☐ The room is spinning and I'm still
- ☐ I feel sick to my stomach
- ☐ I feel like I'm spinning and the room is still
- ☐ Other (Describe) ____

When did you start feeling dizzy?

____

Does any particular body movement cause you dizziness? ______________________

Have you consulted a physician about this problem? __________________________

TINNITUS

Do you have any problems with tinnitus (noise in the ears)?

___ **Yes** ___**No** ___**Not sure**

If yes, please describe the type of noise: ______________________________

Which ear? _____ **Right** _____ **Left** _____**Both**

How often? ____

NOISE EXPOSURE

Do you have a history of exposure to loud noise? ____ **Yes** ____ **No** ____ **Not sure**

If yes, please describe the type of noise and how long you were/have been exposed.

____

Have you been exposed to noise within the last 14 hours? ___**Yes** ___ **No** ___ **Not sure**

Do you wear hearing protection? ___**Yes** ___**No** ___**Not sure**

Do you have trouble hearing in any of the following situations:

- ☐ On the telephone?
- ☐ Watching television?
- ☐ Women's voices?
- ☐ Men's voices?
- ☐ Children's voices?
- ☐ At the movies?
- ☐ At school?
- ☐ At home?
- ☐ With background noise?
- ☐ At concerts/theatre?
- ☐ At parties/social groups?
- ☐ At religious services?
- ☐ At work?

Which ear do you use on the telephone? _______ **Right** _______ **Left**

HEARING AIDS

Have you ever, or do you currently wear hearing aids? ______**Yes** ____**No**

If yes, when did you first start wearing hearing aids? ____________________

Do you wear hearing aids now? ____**Yes** ____**No**

Which ears? ____ **Right** ____**Left** ____ **Both**

Make: ____________________________________Model ________________

When did you get it? _______________ Who recommended it? ____________

How many hours a day do you wear it/them? ________________________________

Are you/were you satisfied with it/them? _____ **Yes** _____ **No**

UNIVERSITY OF FLORIDA SPEECH AND HEARING CLINIC
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(352) 392-2041

I authorize and agree the above named agency to secure and/or release information for professional use.

I also authorize release of information and necessary data pertinent to the filing of insurance claims, request payment of benefits to the party who accepts assignment (if applicable).

Clinical services in Speech and Hearing relate to training programs in these areas. We will appreciate willingness to sign the following statement.

"I agree to permit University Trainees, enrolled in pertinent academic training program participate in the evaluation and/or treatment procedures which will be conducted under supervision of the faculty of the Clinical Training Programs. In addition, I agree to permit the use of closed circuit television, the taking of photographs or motion pictures and other recording or similar graphic material which are to be used for teaching or scientific purposes."

NAME ____

SIGNATURE____ DATE______________