Lyric Audiology, PLLC

371 State Route 17M, Suite 7
Monroe, NY 10950
(845) 395-0300

ADULT CASE HISTORY

Date________________________________

Name ____ D.O.B.________________________

Address:____

____

Phone: (h) ___________________________(c)_____________________________(w)________________________

E-Mail: ____

MAIN REASON FOR TODAY'S VISIT: ____

____

1. **History of Hearing Loss**: ___Yes ______ No Which Ear : _____Right _____Left _____Both
   Age at onset: _____________ Date of last hearing test: ________________________
   Has the hearing loss been: _____Gradual _____Sudden _____Fluctuating

2. **Does anyone in your family have a hearing loss?** _____Yes _____No
   If so, who?____ ___________________

3. **EAR INFECTIONS** _____Yes _____No Which Ear : _____Right _____Left _____Both
   Age at onset: _____________ Do/did you experience: _____Drainage _____Pain ______Fullness
   When was your last infection?____
   Have you ever had any medical treatment for your ears?____

4. **EAR SURGERY** _____Yes _____ No Which Ear : _____Right _____Left _____Both
   Date ____
   Describe ____

5. **TINNITUS** _____Yes _____ No Which Ear : _____Right _____Left _____Both
   _____Ringing _____Hissing _____Pulsating ________Other
   _____Constant _____Occasional _____Rarely

6. **VERTIGO/DIZZINESS** _____ Yes _____No
   Rotary (spinning) _____Yes _____No
   Light-headedness _____Yes _____No
   Unsteadiness _____Yes _____No

7. **HEAD INJURIES** _____Yes _____No If yes, when________________
   Describe ____

   ____

OVER PLEASE

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8. **NOISE EXPOSURE** _____Yes ____No _____Occupational _____Military _____Recreational

Describe ____
Duration ____
How recently ____

9. **GENERAL MEDICAL HISTORY: please check all that apply**

_____Diabetes _____High Blood Pressure _____Cancer _____Neurological _____Kidney
_____Thyroid _____Heart _____Allergies (specify) _______Visual _____Viral or Bacterial Infections
(please specify, e.g., meningitis) _____Childhood diseases (measles, mumps etc.) _________Surgeries
_____Other (describe)

Remarks ____

____

10. **MEDICATIONS**

Please list any current medications (include all prescription/non-prescription vitamins, supplements, etc.)

____

____

____

Please list any previous medications especially any long term antibiotics, anti-neoplastics or radiation therapy____

____

11. **Have you ever, worn a hearing aid?** ____Yes ___ No Which Ear : __Right ___Left ___Both

If yes, are/were you satisfied? _____Yes _____ No

Why/Why not? ____

____

If you do need hearing aids, how motivated are you to wear them? What would be your greatest obstacle in getting hearing aids?

____

____

12: **What are your greatest communication difficulties? (e.g., TV, phone, groups, etc.)**

____

____

____

____

13: **Do you have any additional comments?**

____

____

____