



**Preferred Audiology Services – Partners in Hearing Healthcare**

121 Congressional Lane, Suite 310, Rockville, Maryland 20852

(301) 468-0551 (301) 943-3318 (301) 937-0488 fax

## Case History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

*To ensure the best hearing healthcare, please answer the following questions to the best of your knowledge:*

1. Are you having difficulty hearing/understanding speech?  Yes  No

If yes, check the listening situations you are having difficulty in:

meetings  group gatherings  restaurants  
 one-on-one  television  men's voices  
 women's voices  children's voices

2. How long have you been experiencing difficulty in hearing? \_\_\_\_\_

3. Did your hearing loss come on suddenly or was it gradual? \_\_\_\_\_

4. Do you have tinnitus?  Yes  No

In which ear?  Right  Left  Both

Is it constant?  Yes  No

When did you first notice it? \_\_\_\_\_

Briefly describe your tinnitus: \_\_\_\_\_

5. Do you experience dizziness/vertigo?  Yes  No

If yes, briefly explain: \_\_\_\_\_

6. Do you have family members who have hearing loss?  Yes  No

mother  father  maternal grandmother  
 maternal grandfather  paternal grandmother  
 paternal grandfather  brother  sister  aunt  uncle  
 cousin  other

7. In the past 90 days, you have experienced:

ear pain R/L  drainage from ear(s) R/L

sudden change in hearing R/L  treated by a physician for ear problems

8. Do you have a history of noise exposure?  Yes  No  
 military  work  recreational  seasonal hunting  
Did you wear hearing protection during this exposure?  Yes  No

9. Do you have a history of ear infection or problems that need or needed medical treatment?  Yes  No

If yes, please briefly explain: \_\_\_\_\_  
\_\_\_\_\_

10. Do you wear hearing aids?  Yes, in my  Right ear  Left ear  
No. of years wearing hearing aid(s) \_\_\_\_\_  
 No

Please briefly state the purpose for today's visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**All information provided by you will be held in confidence. No information will be released without your prior written consent.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

For Audiologist Use: