

Parrs Pro Hearing Services
Susan Parr – Doctor of Audiology
Habersham Medical Center
Adult Case History Form

Patient Name: _____ **Date of Completion:** _____

Date of Birth: _____ **Gender:** _____ **Primary Language:** _____

Marital Status: Single Married Divorced Widowed Domestic Partner

Race: White African-American Asian American Indian Other: _____

Ethnicity: Hispanic or Latino

Current Employment Status: Full-time Part-time Retired Unemployed

Stay at Home Parent Student

Current Employer: _____ **Position:** _____

Highest Level of Education: _____

Do you currently use recreational drugs? Yes No

If yes, what drugs: _____

How often: Daily Weekly Monthly Occasionally Rarely

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months? Yes No

If yes, how often have you used a tobacco product in the past 24 months? _____

If yes, what do you use: Cigarettes Cigars Pipe Smokeless Other: _____

If yes, amount of use per day: _____

Do you currently drink alcoholic beverages? Yes No

If yes, how often: Daily Weekly Monthly Occasionally Rarely

Medical History

Current Medications:

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Allergies (foods, medications, plastics, etc.): _____

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence: _____

Have you been immunized? Yes No

If yes, for what illnesses or diseases: _____

Have you experienced any of the following major medical conditions (please check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Autoimmune | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Genetic Disorders | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Migraines | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COVID-19 | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Fevers | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Influenza | <input type="checkbox"/> Vascular Problems |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other: _____ |

Please check all medical symptoms or conditions that apply:

- Eye problems (i.e.: blurred or double vision, pain): Yes No
- Nose, throat, or mouth problems (i.e.: trouble swallowing, nose bleeds, dental issues): Yes No
- Cardiovascular issues (i.e.: hypertension, chest pain, swelling, palpitations): Yes No
- Respiratory issues (i.e.: shortness of breath, cough, wheezing): Yes No
- Gastrointestinal issues (i.e.: nausea, vomiting, weight changes, diarrhea, pain): Yes No
- Musculoskeletal issues (i.e.: joint pain, swelling, recent trauma): Yes No
- Neurological symptoms (i.e.: numbness, headaches, tingling, seizures, muscle weakness): Yes No
- Psychiatric issues (i.e.: depression, anxiety, compulsions): Yes No
- Endocrine symptoms (i.e.: frequent urination, hot flashes): Yes No
- Hematologic/lymphatic symptoms (i.e.: bleeding gums, bruising, swollen glands): Yes No
- Allergic/immunologic symptoms (i.e.: hives, asthma, itching, immune deficiency): Yes No

Comments related to Review of Symptoms above: _____

Audiologic History

Do you experience hearing loss? Yes No

If so, which ear? Right Left Both

If you experience hearing loss, which best describes it? Gradual Fluctuating Sudden

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Have you ever experienced dizziness, unsteadiness, imbalance, or vertigo? Yes No

If yes, are you feeling dizzy today? Yes No

If yes, please describe: _____

Frequency of occurrence: _____

If yes, is it accompanied by nausea ringing or noises in your ear hearing loss visual disturbances

Have you fallen within the past 12 months? Yes No

If yes, how many falls have you experienced in the 12 months? _____

If you have fallen, have you been injured? Yes No

Please describe your injury: _____

Do you experience visual difficulties or disturbances? Yes No

If yes, please describe: _____

Do you currently take a Vitamin D supplement? Yes No

Have you ever had a hearing test? Yes No

If so, when: _____

Which ear do you typically use to talk on the telephone: Right Left

Have you ever worn or tried a hearing aid or amplifier? Right ear Left ear Both ears

What type and/or style of hearing aid or amplifier: _____

Please describe your experience: _____

Please check all of the medical conditions that apply:

Developmental disorder/delay

If checked, please explain: _____

Ear deformity

If checked: Right ear Left ear Both ears

Ear drainage

If checked: Right ear Left ear Both ears

Ear pressure

If checked: Right ear Left ear Both ears

- Ear pain**
If checked: Right ear Left ear Both ears
- Family history of hearing loss**
If checked, who is the family member: _____
- History of ear infections**
If checked: Right ear Left ear Both ears
- History of earwax buildup**
- History of noise exposure**
 Occupational Recreational Military Do You Use Hearing Protection
- Previous ear surgery**
If checked: Right ear Left ear Both ears
If so, when: _____
- Tinnitus/ringing/noises in ears**
If checked: Right ear Left ear Both ears
 Intermittent Constant Pulsed Single sound Multiple sounds
 Hyperacusis (Sensitivity to Loud Sounds)
- Other (please describe):** _____

Hearing Handicap Screening (please select the most appropriate response):

- **Does a hearing problem cause you to feel embarrassed when meeting new people?**
 Yes No Sometimes
- **Does a hearing problem cause you to feel frustrated when talking to members of your family?**
 Yes No Sometimes
- **Do you have difficulty hearing when someone speaks in a whisper?**
 Yes No Sometimes
- **Do you feel handicapped by a hearing problem?**
 Yes No Sometimes
- **Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?**
 Yes No Sometimes
- **Does a hearing problem cause you to attend lectures or religious services less often than you would like?**
 Yes No Sometimes
- **Does a hearing problem cause you to have arguments with family members?**
 Yes No Sometimes
- **Does a hearing problem cause you difficulty when listening to TV or radio?**
 Yes No Sometimes
- **Do you feel that any difficulty with your hearing limits or hampers your personal or social life?**
 Yes No Sometimes
- **Does a hearing problem cause you difficulty when in a restaurant with relatives and friends?**
 Yes No Sometimes