GREENSPAN AUDIOLOGY
CASE HISTORY FORM

Name: _____ Date: _____

1. How can we help you? _____

2. Are you having pain, fullness, or drainage in or around your ears? If so, which ear? _____

3. Are you hearing any noises in your ears or head? _____

4. Are you having any dizziness, light headedness, or loss of balance? _____

5. How is your hearing? _____

6. How well do you hear on a telephone? _____

7. Which ear do you use on the telephone? _____ Is it a habit or do you hear better in that ear? _____

8. Have you had surgery under general anesthetic during the past 5 years? _____

9. Have you ever had surgery on your ears? _____

10. Please list all medications, vitamins, supplements, etc. you are taking _____

11. Have you ever had any sudden changes in your hearing or in the past 90 days? _____

12. Have you ever been exposed to any extremely loud noise? _____

13. Is there anyone in your family with problems with their hearing? _____

14. Have you ever had problems with your heart or blood pressure? _____ Have you ever had a stroke? _____

Name: _____ Date: _____

15. Have you ever worn a hearing aid? _____ Do you need them? _____

16. When was the last time you had your hearing tested? _____

17. Are you a diabetic? _____ Do you have diabetes in your family? _____

18. How long have you noticed your hearing loss? _____

19. Was your hearing loss sudden or gradual? _____

20. Have you ever had a serious trauma or blow to the head? _____

21. Do you have excessive ear wax or need to clean your ears often? _____

22. Would you like me to send a copy of our findings to your physician so he/she will have a full record of your health? _____