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? _______________________________________