CASE HISTORY

Lifestyle Hearing of Utah
Audiology & Hearing Aid Center

Last Name: ______________________ First Name: ____________________ Date: ________________

Address: ______________________________ City: ________________ State: _____ Zip: ___________

Phone: _______________ Cell Phone: ________________ Email: ________________________________

Date of Birth: ___/___/_____ Male / Female Married / Single / Widow(er)

Accompanying Party or Companion: __________________________ Relationship: ___________________

Family Physician Name: _______________________ City: _________________ Phone: ______________

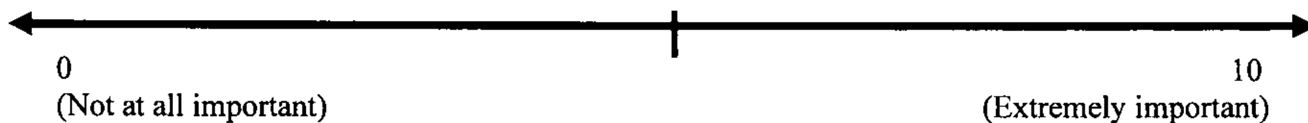
Copy of your test sent to your physician? Yes ___No ___ If yes, we will provide you a separate release to sign.

Presenting Problem

1. What is your primary complaint about your ears or hearing? ___________________________________
2. What do you think caused your hearing problem? ____
3. If you have a hearing loss, how long have you noticed this? __________________________________
4. Which is your worse ear (if they are different): Left _____ Right _____ They are the same _____
5. Do you have difficulty understanding:

   TV: Yes_____ No_____ Telephone: Yes_____ No_____ In groups: Yes _____No_____

6. How important is it for you to improve how you hear, understand, or communicate with others RIGHT NOW (mark on the line)



0 (Not at all important) 10 (Extremely important)

History

1. Have you had your hearing tested before? Yes_____ No_____ If yes, when and where?:

____

2. Any drainage from the ear within the past 90 days? Yes_____ No_____
3. Have you experienced any dizziness, balance problems, or falls? Yes_____ No_____
4. Have you ever lost hearing in one ear *suddenly*? Yes_____ No_____

Please complete other side

5. Do you have any noises or ringing in your ears? Yes_____ No_____ Left / Right / Both

If present, is it: Constant _____ Intermittent _____ When did you first notice it? ____________________

6. Have you had pain in your ears in the past 10 days? Yes _____ No _____

7. Have you received any medical or surgical treatment for hearing loss? Yes_____ No______

8. Do you have trouble with arthritis, stiffness, numbness in your fingers? Yes_____ No_____

9. Have you ever been exposed to loud noise? Military Occupation/Job Recreational

If yes, describe the type of noise: ____

Did you use ear plugs/muffs? Yes_____ No_____

10. Is there a history of hearing loss in your immediate family? Yes_____ No_____

If yes, who: ____

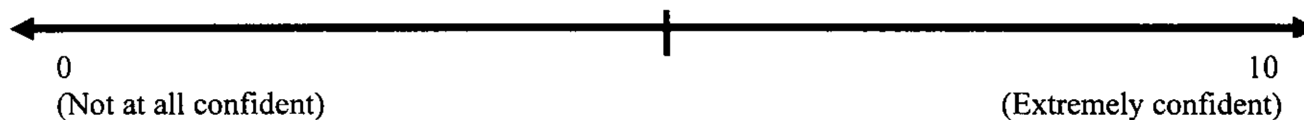
11. Medical problems (check all that apply):

Infectious disease _____ Diabetes _____ Heart problems _____ Head injury ____
High blood pressure _____ Headache _____ Kidney failure _____
Pacemaker/Defibrillator _____
Other (please explain): ____

12. Have you ever worn a hearing aid(s)? Yes _____ No _____

If yes, how would you rate your experience with your hearing aid(s) on a numerical scale of 0 (terrible) to 10 (great)? _________

13. How confident are you in your own ability to use and take care of hearing aids if they are recommended? (mark on the line)



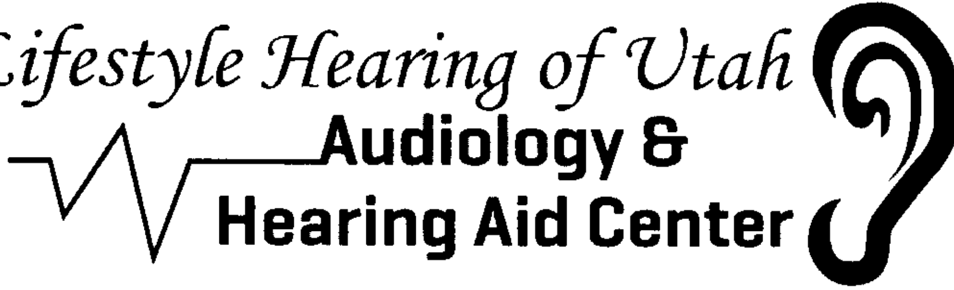
0 (Not at all confident) — 10 (Extremely confident)

14. In what situations would you most like hearing aids to help you (if recommended)?:
Conversations with family or friends _____ TV _____ Telephone _____ In the car _____
Places of worship _____ Music ____ Other: ____________________

15. Select all that apply:
_____ I am not ready for hearing aids at this time.
_____ I have been thinking that I might need hearing aids._
_____I have started to seek information about hearing aids.
_____ I am ready to wear hearing aids if they are recommended.
_____ I am comfortable with the idea of wearing hearing aids.
_____ I currently wear hearing aids.

Comments or questions for the audiologist:

NAME ____________________



PRE – POST QUESTIONNAIRE

	PLEASE PLACE AN "X" IN ONE OF THE COLUMNS TO THE RIGHT OF EACH QUESTION. DO NOT SKIP ANY QUESTIONS.	YES	SOMETIMES	NO
1	Does a hearing problem cause you to feel embarrassed when you meet new people?			
2	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
3	Do you have difficulty hearing when someone speaks in a whisper?			
4	Do you feel handicapped by a hearing problem?			
5	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
6	Does a hearing problem cause you to attend religious services less often than you would like?			
7	Does a hearing problem cause you to have arguments with family members?			
8	Does a hearing problem cause you difficulty when listening to TV or radio?			
9	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
10	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			
	TOTALS			