CALIFORNIA STATE UNIVERSITY, FRESNO
Speech and Hearing Clinic

AUDIOLOGY CASE HISTORY – ADULT

Name_____ DOB_____ Gender_____
Occupation_____ Referral _____
Statement of the problem_____
What do you think caused the problem?_____
Have you ever had a hearing evaluation?_____ Where and when?_____

Audiological History

Do you suspect you have a hearing loss? _____ If so, describe _____
How old were you when you first suspected a hearing loss?_____
Has it changed since its onset?_____ Does your hearing change from day to day?_____
Does your hearing loss interfere with your work?_____ Explain_____
Is the speech of your family clear to you?_____ Explain_____
Is the speech of others clear to you in a noisy room?_____ Explain _____
Have you ever tried a hearing aid?_____ What type?_____ Which ear?_____
How long?_____ Are you satisfied with your hearing aid(s)?_____ Explain_____
_____

Medical History

What other medical problems do you have?_____
Do you get dizzy?_____ Describe your dizziness (lightheaded, off balance, spinning, etc.)
_____How long does it last?_____
How often does it occur?_____ Do you get nauseated with the dizziness?_____
Do you have some warning before a dizzy spell?_____ Explain:_____
Describe any noise (tinnitus) in your ears_____ Which ear?_____
When is it most noticeable?_____ How long have you had it?_____
Do you have any numbness or tingling in your face?_____ Which side?_____
Did you notice any hearing difficulties after having measles? _____, mumps?_____,
scarlet fever? _____,chicken pox? _____, shingles? _____
Have you ever taken any of the following drugs? streptomycin_____, vancomycin _____,
gentamicin _____, cisplatin _____, carboplatin _____, any diuretic (Lasix) _____

Other History

Have you ever worked in a noisy place? _____ If so, where?_____
For how long?_____ How often did you wear hearing protection?_____
What other forms of noise exposure have you had (concerts, firearms, music, construction, carpentry, aircraft, etc.) _____

Tell me: The types of problems you have experienced because of your hearing loss? _____
_____How your listening difficulties (hearing loss) affects your everyday life? _____The kinds of activities that you like to do?_____
The problems you experience in performing these activities that are associated with your listening difficulties (hearing loss)? _____
The activities that you find more difficult to do now than in the past because of your listening difficulties (hearing loss)? _____
The activities that you would like to do that you have stopped doing because of your listening difficulties (hearing loss)? _____
Any new activities that you would like to try? _____