

**About Better Care Audiology  
W3124 Van Roy Road  
Appleton, WI 54915  
920-915-9077 -**

**Adult Case History**

Name:	
Date:	

1. Do you feel that you are experiencing a hearing problem?  Yes  No  
If yes, how long have you been aware of the problem?
  
2. Do you feel that one ear is better than the other?  Yes  No  
If so, which is your better ear?  Right  Left
  
3. In what listening situations do you have difficulty hearing? (i.e., one-on-one conversations, groups, work, church, restaurants, TV, theaters, etc.)
  
4. Have you ever worn a hearing aid?  Yes  No  
If yes, for how long?
  
5. Have you ever had medical treatment or surgery for ear problems?  Yes  No
  
6. Have you had any recent ear pain or drainage?  Yes  No
  
7. Do you have any allergies?  Yes  No
  
8. Do you ever experience noises in your ears?  Yes  No  
(i.e., ringing, buzzing, etc.)
  
9. Have you experienced dizziness or loss of balance within the last 90 days that you cannot relate to a specific cause?  Yes  No



10. Have you ever experienced a serious head injury? Yes No
11. How would you describe your general health? Good Average Fair Poor
12. Are you currently taking any medications? Yes No

If so, please list what conditions they are for:

13. Have you ever had a serious illness that may have affected your hearing?  
(i.e., scarlet fever, meningitis, mumps, etc.) Yes No

14. Have you ever been exposed to high levels of sound? (i.e., farm equipment,  
power tools, lawn movers, chain saws, snow blowers, industrial machinery,  
firearms, etc.) Yes No

15. Does anyone in your family have a hearing loss?  
If so, what caused it? Yes No

16. Do you have any other significant health problems or handicaps? Yes No

17. Do you have any speech, language, or voice problems? Yes No

18. What questions or problems would you like help with today?

