

Lafayette Hearing Center

Case History

Date: ___/___/___

Patient Name: _____ **DOB:** ___/___/___ **Age:** _____

Address: _____ **Male** **Female**

Insurance: _____ **Phone:** _____

Occupation: _____ **Email:** _____

Family Member: _____ **Family Member Phone:** _____

Previous Hearing Test? **Y** **N** If yes, when/where? _____
 Recommendations? _____

When did you first notice a hearing problem?

recently 1-3 years 4-6 years 7-10 years + 10 years

Is one ear better than the other? **Y** **N** If yes, which ear? **R** **L**

Which ear do you use for the telephone? **R** **L**

Do people in your family think you have trouble hearing? **Y** **N** If yes, who? _____

Does anyone else in your biological family (i.e. siblings, parents) have hearing problems? **Y** **N**

If yes, who? _____

Do you or have you worked in a noisy place? **Y** **N**

Do you have noisy hobbies? **Y** **N**

Notes: _____

Do you currently wear a hearing aid? **Y** **N** If yes, **Right** **Left** **Both**

Other Medical History

	Yes	No	Details
Middle ear infections?			
Ear Surgery?			
Ear Pain?			
Sinus/Allergies?			
Frequent ear aches/draining ears?			
Head or face injury?			
Ringing/buzzing in ears?			
Balance problems? (spinning <input type="checkbox"/> , unsteady <input type="checkbox"/> , acute <input type="checkbox"/>)			
High Blood Pressure?			
Diabetes?			
Do you take regular aspirin?			
Do you take calcium supplements?			

List all medications/herbal supplements, check if list attached :

Does a hearing problem:

	Always	Sometimes	Never
Make you uncomfortable meeting new people?	1	2	3
Cause you to feel frustrated talking to family members?	1	2	3
Make it hard for you to talk on the phone?	1	2	3
Make it hard for you to converse in a restaurant?	1	2	3
Cause you to have to ask people to repeat themselves?	1	2	3
Cause you to have difficulty hearing in background noise?	1	2	3
Cause you to have more trouble hearing women or children?	1	2	3
Cause you to feel like everyone mumbles?	1	2	3
Cause you to not attend public meetings or religious services?	1	2	3
Cause you to have arguments with family or friends?	1	2	3
Cause you to feel stressed or tired when listening for a long time?	1	2	3
Cause others to complain that you have the TV too loud?	1	2	3
Limit your personal or social life?	1	2	3
Cause you to hear people speak but fail to understand what they are saying?	1	2	3

Please tell me 3 listening situations where you wish you could hear better:

1. _____
2. _____
3. _____

Please Select your current lifestyle, and if different, please identify your desired lifestyle:

Active Lifestyle (Frequent Background Noise)

- Current Desired
- Meetings, Group Activities, Shopping Malls, Family gatherings, Diverse restaurants, Demanding Career, Sporting Events, all TV, driving

Casual Lifestyle (Occasional Background Noise)

- Current Desired
- Small meetings, small family groups, small shops, most television, quiet restaurants, religious services, driving

Quiet Lifestyle (Limited Background Noise)

- Current Desired
- One-on-one conversations, visitors, religious services, quiet shops, some television

Very Quiet Lifestyle (Rare Background Noise)

- Current Desired
- Limited visitors, small religious services, limited television