UCA SPEECH-LANGUAGE HEARING CENTER
201 Donaghey Ave/UCA Box 4985 – Conway, Arkansas 72035-0001 – 501-450-3176

Adult Audiological Case History

Name: _____Date: _____
Address: _____
_____Phone: _____
Email Address: _____
DOB: _____Age: _____Gender: _____
Referred by: _____

Please circle or fill in the blanks:

1. Occupation (if retired, please put former occupation) _____
   Is / was this a noisy workplace? Yes No

2. Do you have a hearing loss? Yes No
   If yes, when was your hearing loss first noticed and by whom? _____
   _____

3. What do you feel caused the problem? _____
   _____

4. Have you seen anyone about your hearing loss? If so, please indicate who, when and describe any treatment / results.
   _____
   _____
   _____

5. Has your hearing changed in the last 6 months? _____1 year? _____2 years?_____

6. Does your hearing change or stay the same? Changes Same

7. Do you have a "better ear? No Right Left

8. Do you ever have a ringing or buzzing in: both ears right ear left ear constant occasional
   Does the ringing keep you from sleeping? Yes No

9. Do you ever feel dizzy? Yes No
   If yes, please describe: _____
   _____

10. Do you hear better in a noisy place or a quiet place? Noisy Quiet

11. What are your most difficult listening conditions? _____
_____

12. Have you ever been exposed to loud noises? _____
If so, please describe: _____
_____

13. Have you ever worn hearing aids? Yes No
    * Do you wear hearing aids now? Yes No
    * When did you first start wearing hearing aids? _____
    * Who recommended them? _____
    * Have your aids been satisfactory / unsatisfactory? Please describe: _____
    _____
    * When did you purchase your present hearing aids? _____
    * How many hours a day do you wear your aids? _____
    * In what situations is your aid most helpful? _____
    Least helpful? _____

14. Does anyone in your family have a hearing problem? If so, please explain
_____
_____

15. Have you ever had any of the following? Please indicate the age at which it occurred.

Scarlet Fever _____	Concussions _____
Mumps _____	Seizures _____
Ear aches _____	High Fevers _____
Sinus _____	Ear Surgery _____
Measles _____	Cancer Treatment _____
Meningitis _____	Kidney Problems _____
Diabetes _____	Heart Condition _____

Other: _____
_____

16. Do you have any allergies? If so, please describe: _____
_____

17. Please list medications you are taking and for which condition they are prescribed:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____