



Salem Audiology Clinic, Inc.

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ADULT CASE HISTORY

Name: _____ Date of Birth: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 SSN: _____ Occupation: _____ Spouse: _____
 Physician: _____ Clinic address, if known: _____
 E-mail Address: _____
 How did you hear about us? _____

**** All contact information, including e-mail address, will be used strictly for issues related to today's visit and any necessary future contact. It will not be disclosed to outside sources beyond the scope of our patient privacy policy. Your initials: _____**

What is your goal for today's appointment?? _____

- Ear, Hearing & Noise Exposure History -

(Please circle appropriate answer and provide more information where necessary.)

Known Hearing Loss? Yes No
 Right Left Both
 How long? _____
 Gradual? Sudden? Fluctuating?

Past Ear Surgery? Yes No
 Right Left Both
 Describe: _____

Recent Ear Pain? Yes No
 Right Left Both
 Describe: _____

Recent Ear Drainage? Yes No
 Right Left Both
 Describe: _____

Full/plugged sensation? Yes No
 Right Left Both
 How long? _____

Tinnitus (ringing/other noises in ears)? Yes No
 *If yes, please answer more questions on reverse.

Dizziness/Balance problems? Yes No
 Does the room spin? Yes No
 How long have you had problem? _____
 How frequently does it occur? _____
 Duration of an episode? _____

Family History of Hearing Loss? Yes No
 Who? _____

Have you ever worked in noise? Yes No
 Military? Yes No
 Describe: _____

Noisy Hobbies:
 Firearm use? Yes No
 Loud music/concerts? Yes No
 Other: _____

- Other Medical History -

(Please circle if you have or have had any of the following)

Allergies	HIV/AIDS	Other Significant Health	Medications: _____
Cancer	Kidney Disease	Issues: _____	_____
Cerebral Palsy	Meningitis	_____	_____
Diabetes	Multiple Sclerosis	_____	_____
Head Injury	Mumps	_____	_____
Heart Attack	Stroke	_____	_____
High Blood Pressure	Other communicable disease	_____	_____

**** PLEASE TURN OVER ****

HEARING LOSS ASSESSMENT

Hearing Handicap Inventory

	Yes	Sometimes	No
1. Does your hearing problem cause you to feel embarrassed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your hearing problem cause you to feel frustrated when talking to family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have difficulty hearing when someone speaks in a whisper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you believe your hearing problem has affected work or similar situations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your hearing problem cause you difficulty when visiting friends or family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your hearing problem cause you to avoid large group situations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your hearing problem cause you to have arguments with friends or family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your hearing problem cause you difficulty when listening to TV or radio?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your hearing problem hamper your personal or social life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does your hearing problem cause you difficulty when in a noisy situation like a restaurant or party?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list four specific goals for improving your hearing:

1. _____ 3. _____
 2. _____ 4. _____

If you have worn hearing aids before, please answer the following:

HEARING AID HISTORY

How long have you worn hearing aids? _____

Where did you purchase them? _____

How satisfied are you with your hearing aid(s) in the following situations?

At home, one-on-one conversations	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
In background noise (i.e. restaurants)	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
On the Telephone	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
On a cellular telephone	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
Riding in the car	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
At Work	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
Television	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor
In a large room	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Poor

Are you here to replace your hearing aids if something better is available? Yes Maybe No

If you answered "yes" that you have tinnitus (ringing or other sounds in your ears), please answer the following:

TINNITUS ASSESSMENT

Description of how your tinnitus

What does it sound like?

- | | | |
|----------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Ringing | <input type="checkbox"/> Roaring | <input type="checkbox"/> Rushing |
| <input type="checkbox"/> Hissing | <input type="checkbox"/> Pulsating | <input type="checkbox"/> Warbling |
| <input type="checkbox"/> Musical | <input type="checkbox"/> Other: _____ | |

How often do you hear it?:

- | | | |
|---------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Constantly |
|---------------------------------|---------------------------------------|-------------------------------------|

Duration:

- | | | |
|-------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Rare | <input type="checkbox"/> Occasional | <input type="checkbox"/> Constant |
|-------------------------------|-------------------------------------|-----------------------------------|

Loudness:

- | | | |
|------------------------------------|-------------------------------|----------------------------------|
| <input type="checkbox"/> Very Loud | <input type="checkbox"/> Loud | <input type="checkbox"/> Present |
|------------------------------------|-------------------------------|----------------------------------|

How Does Your Tinnitus Affect You?

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| Make you irritable or nervous? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Make you tired or stressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Affect your sleep habits? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Make it difficult to relax? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Make it difficult to concentrate? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Interfere with your work? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Interfere with social activities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Make you depressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Affected you otherwise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Describe: _____
