Alabama A & M University
**Speech-Language-Hearing Clinic**
P.O. Box 357
Normal, Alabama 35762
Phone: (256) 372-5534 or (256) 372-4044

# AUDIOLOGY
# CASE HISTORY FORM – ADULT

Name _____ Sex _____ Marital Status _____

Birthdate _____ Age _____ Today's Date _____

Address: _____ Home Phone _____

City _____ State _____ Zip _____ Cell phone _____

Place of Employment or Previous Employment

Address: _____ Home Phone _____

City _____ State _____ Zip _____ Cell phone _____

Name of alternate contact person _____ Relationship _____

Address: _____ Home Phone _____

City _____ State _____ Zip _____ Cell phone _____

Who referred you to the AAMU Speech and Hearing Clinic? _____

To what professional person(s) or agency (ies) do you want a report sent? Please include names of professionals and addresses: _____

_____

_____

Have you ever had a hearing test here before? ☐ Yes ☐ No

If so, when?_____

Do you have any problem hearing? ☐ Yes ☐ No

Which ear do you hear better with? ☐ Right ☐ Left ☐ Both are the same

If not, for what reason were you referred to have a hearing test? _____

Has the hearing loss been: ☐ Gradual ☐ Sudden ☐ Fluctuating

What do you think may have caused your hearing problem? _____

_____

Can you hear with either ear on the telephone? ☐ Yes ☐ No

Which ear do you use on the phone? ☐ Right ☐ Left

Have you ever had any ear infections? ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both

Have you ever had ear surgery or PE tubes? ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both

Does anyone in your family have a hearing problem? ☐ Yes ☐ No

Do you hear noises in your ear or head? ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both

Check those that best describe the noises that you hear:

☐ High-pitched ringing ☐ Buzzing ☐ Crickets

☐ Roaring ☐ Pulsating ☐ Rushing water

☐ Other: _____

How often do you have the noises?

☐ Constantly ☐ Frequently ☐ Occasionally

When did they begin? _____

Are you having a dizziness problem: ☐ Yes ☐ No

If so, when did this begin? _____

Is your dizziness accompanied by:

Nausea? ☐ Yes ☐ No

Vomiting? ☐ Yes ☐ No

Noises in your ear(s)? ☐ Yes ☐ No

Check any illness that you have had:

☐ Meningitis ☐ Mumps ☐ Malaria ☐ Diabetes

☐ Heart Trouble ☐ High Blood Pressure ☐ Head Injuries ☐ Scarlet Fever

Do you take medicines regularly? ☐ Yes ☐ No

If so, please list: _____

Have you been exposed to loud noises for any length of time? ☐ Yes ☐ No

If so, please describe: _____

What is, or was, your occupation? _____

Have you ever used a hearing aid? ☐ Yes ☐ No

Are you interested in pursuing hearing aid use? ☐ Yes ☐ No

Please check the appropriate response. Are you:

☐ Right handed ☐ Left handed ☐ Use both equally

What is your native language? _____