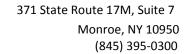


371 State Route 17M, Suite 7 Monroe, NY 10950 (845) 395-0300

ADULT CASE HISTORY

				Date			
Name					D.O.B		
Ad	ldress:						
Ph	none: (h)		(c)		(w)		
E-l	Mail:						
1.	HEARING LOSS:	Yes	No	Which Ear	:Right	Left	Both
	Age at onset:						
	Has the hearing loss	s been:(Gradual _	Sudden	Fluctuating		
R	emarks						
2.	FAMILY HISTORY	OF HEARING L	.oss	YesN	lo Relationship:		
Re	emarks						
3.	EAR INFECTIONS	Yes	No	Which Ear : _	Right	Left	Both
	Age at onset:	Did	you experie	enceDrain	age	_Pain	
Re	emarks						
4.	EAR SURGERY	Yes _	No	Which Ear :	Right	Left	Both
	Date						
	Describe						
R	emarks						
5.	TINNITUS Ringing Constant	Yes Hissing Occasional	No Other Ra	Which Ear :	Right	Left	Both
R	emarks						
6.	VERTIGO/DIZZINES: Rotary (spinning) Light-headedness Unsteadiness	Y	/es /es /es	No No No No			
Re	emarks						





7.	HEAD INJURIES	Yes	N	o If yes, when		
	Describe					
	emarks					
8.	NOISE EXPOSURE _	Yes	No	Occupational	Military	Recreational
	Remarks					
9.	GENERAL MEDICAL	HICTORY				
J .	Please check all that a					
			Prassura	Cancer	Neurological	Kidney
	Thyroid	_Heart	Allergies	(specify)Vira	rtearological	ons (please specify
	e.g., meningitis)		diseases			
	Other (describe	•				
	Remarks					
10.	MEDICATIONS					
		nt medications	•			
	Please list any previ	ous medicatio	ns especia	lly any long term antib	iotics, anti-neoplast	cs or radiation
	therapy		·		·	
			40 V	NI. MANISTE	District La	ti Dall
11	. Have you ever, worr	_			ar :RigntLe	IIBoth
	If yes, are/were you s					
	Why/Why not?					
Ado	 ditional Comments/Inforr	mation:				
						<u>.</u>
						