Lyric Audiology, PLLC

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

ADULT CASE HISTORY

Date_____

Name _____ D.O.B._____

Address:_____

_____

Phone: (h) _____(c)_____(w)_____

E-Mail: _____

1. **HEARING LOSS**: _____Yes _____ No Which Ear : _____Right _____Left _____Both

   Age at onset: _____

   Has the hearing loss been: _____Gradual _____Sudden _____Fluctuating

Remarks _____

2. **FAMILY HISTORY OF HEARING LOSS** _____Yes _____No Relationship: _____

Remarks _____

3. **EAR INFECTIONS** _____Yes _____No Which Ear : _____Right _____Left _____Both

   Age at onset: _____ Did you experience _____Drainage _____Pain

Remarks _____

4. **EAR SURGERY** _____Yes _____ No Which Ear : _____Right _____Left _____Both

   Date _____

   Describe _____

Remarks_____

5. **TINNITUS** _____Yes _____ No Which Ear : _____Right _____Left _____Both
   _____Ringing _____Hissing _____Other
   _____Constant _____Occasional _____Rarely

Remarks_____

6. **VERTIGO/DIZZINESS** _____ Yes _____No
   Rotary (spinning) _____Yes _____No
   Light-headedness _____Yes _____No
   Unsteadiness _____Yes _____No

Remarks_____

Lyric Audiology, PLLC

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

7. **HEAD INJURIES** _____Yes _____No If yes, when_____

Describe _____

Remarks_____

8. **NOISE EXPOSURE** _____Yes ____No _____Occupational _____Military _____Recreational

Describe _____

Duration _____

How recently _____

Remarks _____

9. **GENERAL MEDICAL HISTORY**

Please check all that apply

_____Diabetes _____High Blood Pressure _____Cancer _____Neurological _____Kidney _____Thyroid _____Heart _____Allergies (specify) _____Viral or Bacterial Infections (please specify, e.g., meningitis) _____Childhood diseases

_____Other (describe)

Remarks _____

_____

10. **MEDICATIONS**

Please list any current medications _____

_____

Please list any previous medications especially any long term antibiotics, anti-neoplastics or radiation therapy_____

_____

11. **Have you ever, worn a hearing aid?** ____Yes ___ No Which Ear : __Right ___Left ___Both

If yes, are/were you satisfied? _____Yes _____ No

Why/Why not? _____

_____

Additional Comments/Information:

_____

_____

_____

_____