Adult Case History Form

Diane E Williams, Au.D. | *Board Certified Doctor of Audiology*

Appointment Date:

Patient's Name: Preferred Name

Date of Birth: Age: Gender: ☐ Male ☐ Female

Status Marital: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Spouse Name:

Primary Language: Social Security Number:

Address

Street City State Zip

Home Phone #: Cell Phone #:

Email:

Preferred Contact Method: (check all that apply) ☐ Phone ☐ Mail ☐ Email

Current Employment: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Stay at Home Parent ☐ Student

Current Employer (If retired list prior occupation):

Position: Family Physician:

Have you or your spouse ever been in the military? ☐ Yes ☐ No Branch: # of years:

Whom may we thank for referring you:

Reason for Appointment:

Insurance Information - Please give you insurance cards and a photo ID to our front office staff so we can make a copy for our records.

Primary Insurance: Member ID:

Insured's name: Relationship to insured:

Secondary Insurance: Member ID:

Insured's name: Relationship to insured:

For Hearing Aid Wearers, Please Answer the Following:

Do you experience any of the following with your current hearing aid(s) (please check all that apply):

- ☐ Some sounds are too loud
- ☐ Sounds are too soft
- ☐ Pain:
- ☐ Sounds are tinny or metallic
- ☐ Trouble cleaning hearing aid
- ☐ Naturalness of sound
- ☐ Trouble understanding in quiet
- ☐ Wind noise
- ☐ Trouble using telephone
- ☐ Feedback or whistling
- ☐ Trouble changing battery
- ☐ Repair issues
- ☐ Trouble understanding in noise
- ☐ Do not like the appearance of aid
- ☐ Do not like sound of own voice
- ☐ Cannot tell direction of sound
- ☐ Short battery life: (Days)
- ☐ Other

7024 Airway Ave suite D, Yucca Valley, CA 92284
www.bettersoundaudiology.net • (760) 228-1381

Audiologic History

Do you feel you have a hearing loss? ☐ Yes ☐ No Which ear? ☐ Right ☐ Left ☐ Both

If you answered yes, which best describes it? ☐ Gradual ☐ Fluctuating ☐ Sudden

When did you first notice your hearing loss?

What do you think is the cause of your hearing loss?

Have you ever had a hearing evaluation? ☐ Yes ☐ No When/Where?

Which ear do you use to talk on the phone: ☐ Right ☐ Left

Have you ever worn or tried a hearing aid? ☐ Right Ear ☐ Left Ear ☐ Both Ears

What type and/or style of hearing aid:

Please describe your experience:

Please answer the following questions:

Does a hearing problem cause you to feel embarrassed when you meet new people?	☐ **Yes**	☐ **Sometimes**	☐ **No**
Does a hearing problem cause you to feel frustrated when talking to members of your family?	☐ **Yes**	☐ **Sometimes**	☐ **No**
Do you have difficulty when someone speaks in a whisper?	☐ **Yes**	☐ **Sometimes**	☐ **No**
Do you feel handicapped by a hearing problem?	☐ **Yes**	☐ **Sometimes**	☐ **No**
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	☐ **Yes**	☐ **Sometimes**	☐ **No**
Does a hearing problem cause you to attend religious services less often than you would like?	☐ **Yes**	☐ **Sometimes**	☐ **No**
Does a hearing problem cause you to have arguments with family members?	☐ **Yes**	☐ **Sometimes**	☐ **No**
Does a hearing problem cause you difficulty when listening to TV or radio?	☐ **Yes**	☐ **Sometimes**	☐ **No**
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	☐ **Yes**	☐ **Sometimes**	☐ **No**
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐ **Yes**	☐ **Sometimes**	☐ **No**

Please check all medical conditions that apply:

- ☐ Developmental Disorders/Delays *If checked, please explain:*
- ☐ Dizziness or Unsteadiness *If checked, is it accompanied by:* ☐ *Vomiting* ☐ *Nausea* ☐ *Ear Noises*
- ☐ Ear Deformity *If checked,* ☐ *Right ear* ☐ *Left Ear* ☐ *Both ears*
- ☐ Ear Drainage *If checked,* ☐ *Right ear* ☐ *Left Ear* ☐ *Both ears*
- ☐ Ear Pain *If checked,* ☐ *Right ear* ☐ *Left Ear* ☐ *Both ears*
- ☐ Family History of Hearing Loss *If checked, who?*
- ☐ History of Ear Infections *If checked,* ☐ *Right ear* ☐ *Left Ear* ☐ *Both ears* *If so, when?*
- ☐ History of Ear Wax Buildup ☐ *Yes* ☐ *No*
- ☐ History of Noise Exposure *If checked, please describe?*
- ☐ Previous Ear Surgery *If checked,* ☐ *Right ear* ☐ *Left Ear* ☐ *Both ears* *If so, when?*
- ☐ Tinnitus/Ringing/Noises in ears *If checked,* ☐ *Right ear* ☐ *Left Ear* ☐ *Both ears* *Frequency?*

Medical History

Any other illnesses, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence:

Allergies (food, medications, plastics, etc.):

Have you experienced any of the following major medical conditions:

- ☐ AIDS/HIV
- ☐ Appetite Change
- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Encephalitis
- ☐ Fatigue
- ☐ Genetic Disorders
- ☐ Headaches
- ☐ Head Injury
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Fevers
- ☐ Influenza
- ☐ Malaise
- ☐ Malaria
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tonsillitis
- ☐ Typhoid
- ☐ Vascular Problems
- ☐ Other:
- ☐ Memory Issues (including short term loss, Alzheimer's and dementia)

Do you currently use tobacco? ☐ Yes ☐ No

Please Check all medical symptoms that apply:

- ☐ Eye Problems (such as blurred vision, pain):
- ☐ Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain):
- ☐ Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations):
- ☐ Respiratory Symptoms (such as shortness of breath, cough, wheezing):
- ☐ Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain):
- ☐ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma):
- ☐ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness):
- ☐ Psychiatric Issues (such as depression, anxiety, compulsions):
- ☐ Endocrine Symptoms (such as frequent urination, hot flashes):
- ☐ Hemotologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands):
- ☐ Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency):

Additional Comments:

Medication List

Please list all prescriptions, vitamins, and recreational medications

Medication	Dosage	Frequency	Administered

Policy

We ask that all office visits and services be paid at the time they are provided. Although we will gladly bill your insurance when possible, you will be responsible for any unpaid balance by your insurance where applicable.

Initials

Insurance Authorization

I request that payment of authorized benefits be made on my behalf to Better Sound Audiology for services furnished to me by the provider. I authorize any holder of medical information about me to release to Better Sound Audiology any information needed to determine these benefits or the benefits payable for related services.

Initials

Authorization to Release Medical Records

I hereby authorize you to release to my attorney(s), and/or my insurance carrier(s), and/or the referring and/or family doctor, and/or school personnel such medical information as they may require or request.

Initials

Authorization to Contact

II hereby give permission to the individual below to access my audiological information and/or speak on my behalf.

Initials

Name:

Phone #:

Relationship:

Notice of Privacy Practices / Acknowledgement of Receipt

I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the office of Better Sound Audiology & Hearing Aid service a copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

Initials

Signature of Patient	**Signature of Parent or Guardian if patient is a minor and Relationship to the minor**	**Date**