ONSLOW AMBULATORY SERVICES
ONSLOW EAR NOSE & THROAT

55 OFFICE PARK DRIVE I JACKSONVILLE, NC 28456
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AUDIOLOGY Adult Case History

Please complete this form. Attach copies of any additional informational or reports that might assist us in our evaluation.

Name: _____ DOB: _____ AGE: _____ ◯ F ◯ M

Referred by: _____ Occupation: _____

1. Describe your chief complaint or reason for referral: _____
2. Have you had your hearing evaluated previously? ___Yes ____ No If so, where?_____
3. Do you have hearing loss? ____ Yes ____ No If so, which ear? ____ Right ____ Left ____Both
   a. When did it begin? _____ Has it become worse? ____ Yes _____No
4. Is there a family history of hearing loss? ____Yes ____ No
   a. If so who had the hearing loss? _____
   b. What was the age it began? _____
   c. Describe situations where you have a hard time understanding speech:_____
      _____
5. Have you had a history of loud noise exposure? _____Yes _____ No
   a. Where you exposed: _____Work ____Military _____Hobbies (shooting, hunting, woodworking, etc.)
   b. How long where you exposed? _____ Did you use ear protection? ___ Yes ____No
6. Do you hear noise, ringing, or buzzing in the ears? _____ Yes _____ No
   a. If so, in which ear do you hear it? _____ Right _____ Left _____ Both
   b. Describe how it sounds: _____
   c. It is _____ Constant or ____Intermittent.
7. Have you had dizziness or vertigo? _____Yes _____No
   a. If so, describe your symptoms:_____
   b. How long does your dizziness last? ___sec. ____mins. ___hrs. ___days ____weeks ____ constant
8. Have you had surgery on your ears? ____ Yes ____ No
   a. If so, which ear? _____Right ____Left _____Both
   b. If this a post operation evaluation? _____Yes _____ No
   c. What type of surgery did you have? _____
   d. Who performed the surgery? _____

9. Have you had an ear injury and/or head injury? ____Yes ____No
    a. If so, describe _____
10. Have you had ear infections? ____Yes ____ No
    a. What age did they begin? _____ How many have you had? _____
    b. When was the last infection? _____ Have you had drainage? ____Yes _____ No
11. Please check any disease you have had:

    _____ Measles _____Mumps _____Meningitis _____ Malaria

    _____ Diabetes _____Kidney Infections _____ Circulatory problems

    _____ Other_____

12. Do you currently wear hearing aids? _____ Yes _____No
    a. If so, which ear? _____ Right _____ Left _____Both
    b. How long did you or do you use your hearing aids? _____
    c. What type of hearing aids? _____
    d. How did hearing aids benefit you? _____