

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LSU Speech, Language, Hearing Clinic**

**64 Hatcher Hall**

**Baton Rouge, LA. 70803**

**Phone: 225-578-9054**

 **Fax: 225-578-2995**  

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# AUDIOLOGICAL CASE HISTORY for ADULTS

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male / Female

 Last First Middle

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you here today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this been a problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all that apply to you **today**:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| bleeding from ear |  | itching in ear |  | popping in ear |  | stopped up ear |  |
| drainage from ear |  | pain in ear |  | pressure in ear |  |

|  |  |  |
| --- | --- | --- |
|  | **Hearing Loss** | Which ear? Both Right Left |
|  | How long have you had a hearing loss?  |
|  | Was the onset sudden or gradual? |
|  | What caused your hearing loss? |
|  | Do you currently wear a hearing aid?  If yes, how long have you been wearing the hearing aid(s)? |
|  | Have you ever worn a hearing aid?  |
|  | Do you think you need a hearing aid? |
|  | **Tinnitus** (noises or ringing in the ear) | Where is the tinnitus located? |
|  | What does the tinnitus sound like? |
|  | Is the tinnitus constant or intermittent? |
|  | Does the tinnitus keep you awake at night? |
|  | **Dizziness, vertigo, or balance problems** | Constant or intermittent? |
|  | How often do episodes occur? |
|  | How long does an episode last? |
|  | When was your last episode? |
|  | Any nausea or vomiting? |
|  | Have you ever lost consciousness because of the dizziness? |

# AUDIOLOGICAL CASE HISTORY for ADULTS, page 2

Please tell us about any assistive devices you use (such as a wheelchair, cane, walker, hearing aid, etc). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please tell us about any medications you are currently using.

Name of medication: Used for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
|  |

Check all that you have experienced or been diagnosed with. Describe below:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| fluctuating hearing loss |  | trauma or injury to ear |  | surgery on ears |  | cancer |  |
| family history of hearing loss  |  | chronic ear infections |  | headaches |  | ototoxic drugs |  |
| noise exposure |  | headaches |  | jaw pain |  | chemotherapy |  |
| Meniere’s disease |  | tumors |  | mastoiditis |  | allergies |  |
| otosclerosis |  | acoustic neuroma |  | chicken pox |  | sickle cell |  |
| Parkinson’s disease |  | meningitis |  | high blood press |  | measles |  |
| dental or jaw disorders |  | kidney disorders |  | cerebral palsy |  | mumps |  |
| stroke/vascular disease |  | diabetes |  |  |  |

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Is there anything else you would like to tell us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Printed name of person

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_