CONSTANCE BROWN HEARING CENTERS
ADULT CASE HISTORY

Date	**PATIENT INFORMATION**	CBHC#
Name		Age
Employer		
Occupation		Retired? Yes No

PURPOSE OF VISIT

RISK INDICATORS	**YES**	**NO**
Difficulty hearing?		
On a scale of 1-10, with 1 being the worst and 10 being the best, how would you rate your overall hearing ability? 1 2 3 4 5 6 7 8 9 10 (Please circle)		
Is one ear better than the other? Right or Left (Please circle)		
Do you wear hearing aids? Past or Currently (Please circle)		
Noises/ringing/buzzing in your ears (Tinnitus)?		
Dizziness?		
Ear pain, ear drainage, fullness or pressure in the ear?		
Allergies or sinus problems?		
Family history of hearing loss?		
Exposure to loud noises?		
Syndromes or developmental delay?		

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING	**YES**	**NO**
Cancer?		
Diabetes?		
Heart disease?		
High blood pressure?		
Kidney disease?		
Tobacco use?		

Please list any other chronic health conditions you are being treated or monitored for:

MEDICATIONS	**DOSAGE FREQUENCY**		**ORAL/INJECTED/TOPICAL, ETC.**
Include over-the-counter	What strength?	How often?	

DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING YOUR HEARING?