

**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?			