CONSTANCE BROWN HEARING CENTERS
ADULT CASE HISTORY

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

PURPOSE OF VISIT

RISK INDICATORS	**YES**	**NO**
Difficulty hearing (without hearing aids)?		
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?

PLEASE READ AND COMPLETE REVERSE SIDE - SIGNATURES REQUIRED

Revised 6.7.2021

RELEASE / OBTAIN RECORDS / INFORMATION

I authorize Constance Brown Hearing Centers to release/obtain verbally, electronically and/or in writing confidential information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to the employment), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my records to a specific entity and/or person(s), I must specifically state so in writing. This assignment and authorization will remain in effect until revoked in writing by me.

Patient Name _____ Date of Birth _____

Please also share records with (name & address):

Physician

Spouse

Family Member

School

Other

Signature X_____ **Date** _____

Parent/Guardian Signature if Minor X_____ **Date** _____