SOUTHBURY AUDIOLOGY | Cathleen A. Alex, Au.D. Stephanie Bakewell, Au.D.

Adult Case History

Identifying and Family Information

Patient Information:			
Patient Name:	Date of Birth:	Age:	Gender: ☐M ☐F
Street Address:	Town:	State:	Zipcode:
Secondary Address:	Town:	State:	Zipcode:
Primary Phone:	Cell:	Preferred Phone: ☐Home ☐ Cell	
Email:	Marital Status: ☐M ☐S ☐W ☐D ☐SEP		
Occupation:	If retired, former occupation:		
Who referred you to our practice?	Primary Care Physician:		
What is your main concern for today's visit?			

Insurance Information:	
Primary Insurance Company:	Policy Holder's Name:
Policy Holder's Relationship to Patient:	Policy Holder's Date of Birth:
Secondary Insurance Company:	Policy Holder's Name:
Policy Holder's Relationship to Patient:	Policy Holder's Date of Birth:
I authorize payment of medical benefits to Southbury Audiology, LLC for services rendered. I also authorize the release of any medical information to process this claim. I understand that I am responsible for any co-pays, deductibles, or uninsured expenses.	
Signed:	**Date:**

How long have you noticed this problem?

Was the onset sudden or gradual?

Have you previously consulted another professional regarding this problem? If so, whom and when?	☐ Yes ☐ No
Have you ever a hearing test before? Please Explain:	☐ Yes ☐ No
Is the hearing better in one ear? If so, which ear? ☐Right ☐Left	☐ Yes ☐ No
Does your hearing ever change or fluctuate? Please Explain:	☐ Yes ☐ No
Have you ever been exposed to loud sounds? ☐Machinery ☐Music ☐Firearms ☐ Factory ☐ Military ☐Tools ☐Other:	☐ Yes ☐ No
Did you wear hearing protection?	☐ Yes ☐ No
Is there a family history of hearing loss or ear issues? Please Explain:	☐ Yes ☐ No

Do you have ringing or noises in your ears? ☐ Yes ☐ No

☐Right Ear ☐Left Ear ☐Both Ears ☐Constant ☐Periodic, how often:_____

Please describe: ☐Ringing ☐Static ☐Hissing ☐Chirping ☐Pulsing☐Buzzing ☐Other:

Do you have a history of ear infections or surgeries: ☐ Yes ☐ No

Please explain:

In the past 90 days have you experienced any of the following:

☐Ear Pain or Discomfort ☐Right ☐Left ☐Both

☐Ear Drainage ☐Right ☐Left ☐Both

☐Ear Fullness or Pressure ☐Right ☐Left ☐Both

Do you have a history of, or currently have dizziness or vertigo? ☐ Yes ☐ No

Please Explain:

Do you have a history of head, neck, or ear injuries? ☐ Yes ☐ No

Please Explain:

Do you use any form of tobacco? ☐ Yes ☐ No

Please Explain:

Which of these listening situations are problematic for you?

☐ Spouse/Family ☐ Restaurants ☐ Social Settings

☐ Television ☐ Telephone ☐ Place of Worship

☐ Radio ☐ Work ☐ Meetings

☐ Group Gatherings ☐ Hobbies:_____ ☐ Other: _____

Do you currently have hearing aids? ☐ Yes ☐ No

Where and when did you get them?

Do you believe you need hearing aids? ☐ Yes ☐ No

Please rank by order of importance:

☐ Improvement in Quiet ☐Improvement in Noise ☐Cost ☐Cosmetics

Do you believe you have insurance coverage for hearing aids? ☐ Yes ☐ No

If yes, do you know the coverage?

Have you ever been treated for cancer? ☐ Yes ☐ No

Type/Treatment?

Have you ever had, or do you currently have any of the following?

☐ Alzheimer's Disease ☐ Diabetes ☐ HIV ☐ Pacemaker

☐ Anxiety and/or Depression ☐Type I ☐Type II ☐ Malaria ☐ Parkinson's

☐ Arthritis ☐ Heart Issue ☐ Measles/Rubella ☐ Sinusitis/Allergies

☐ Asthma ☐ Headache/Migraine ☐ Menigitis ☐ Stroke/TIA

☐ Bell's Palsy ☐ Hepatitis ☐ Mumps ☐ Tremors

☐ Chronic Congestion ☐ High Blood Pressure ☐ Neurological Issue ☐ Visual Trouble

Are you currently taking any medications? (include over the counter) ☐ Yes ☐ No

Medication	Condition	Dosage	Frequency
