SCH - Adult Case History Questionnaire

second chance hearing inc.

**Second Chance Hearing Center, Inc.**
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**1. Do you believe you have hearing difficulties? If yes, when did you first notice the hearing difficulties.** (required)

- ○ Yes
- ○ No

Additional Comments:

**2. When was your last hearing test & what were the results?**

**3. Have you ever worn or tried hearing aids?** (required)

- ○ Yes - what brand, what style & how long have you worn hearing aids:
- ○ No

Additional Comments:

**4. List family members who have or had hearing loss and the cause of the hearing loss if known:**

**5. Do you have a history of ear infections?** (required)

- ○ Yes - ear infection in the right ear. List below the date of the last ear infection and what was the treatment?
- ○ Yes - ear infection in the left ear. List below the date of the last ear infection and what was the treatment?
- ○ Yes - ear infection in both ears. List below the date of the last ear infection and what was the treatment?
- ○ No history of ear infections.

Additional Comments:

**6. Do you have pain in your ears?** (required)

- ○ Yes - in the right ear
- ○ Yes - in the left ear
- ○ Yes - in both ears
- ○ No

Additional Comments:

**7. Do you feel any pressure in your ears?** (required)

- ○ Yes - in the right ear
- ○ Yes - in the left ear
- ○ Yes - in both ears
- ○ No

Additional Comments:

**8. Do you suffer from allergies or sinus issues? If yes, how often.** (required)

- ○ Yes - constant
- ○ Yes - seasonal
- ○ No

Additional Comments:

**9. Do you hear any sounds in your ears? If so, which ear, when did it start and describe the sound.** (required)

- ○ Yes - constant ringing in both ears
- ○ Yes - occassional ringing in both ears
- ○ Yes - constant humming to buzzing in both ears
- ○ Yes - sounds like a heartbeat in both ears
- ○ Yes - constant ringing in the right ear
- ○ Yes - constant ringing in the left ear
- ○ Yes - constant humming to buzzing in the right ear
- ○ Yes - constant humming to buzzing in the left ear
- ○ Yes - sounds like a heartbeat in right ear
- ○ Yes - sounds like a heartbeat in left ear
- ○ Yes - other. (Please describe in the comment box.)
- ○ No sounds are present in the ears.

Additional Comments:

**10. Have you had any trauma to the head or the ears?** (required)

- ○ Yes (Please describe in the comment box.)
- ○ No

Additional Comments:

**11. Have you had any surgeries to your ears? List the date and the cause.** (required)

- ○ Yes - surgery to the right ear. List date and cause below.
- ○ Yes - surgery to the left ear. List date and cause below.
- ○ Yes - surgery to both ears. List date and cause below.
- ○ No surgeries or procedures to the ears.

Additional Comments:

**12. Have you been exposed to loud noise? What type of noise? When was the occurance?** (required)

- ○ Yes - recreational exposure (please describe in the comment box)
- ○ Yes - Military Exposure (please indicate branch of service, years served, right handed or left handed shooter, and types of exposure in the comment box
- ○ No noise exposure

Additional Comments:

**13. Did you or do you wear hearing protective devices around loud noise?** (required)

- ○ Yes - ear muffs were/are used
- ○ Yes - ear plugs were/are used
- ○ Yes - other form of ear protection used (Please describe in the comment box.)
- ○ No form of ear protective devices have been used.

Additional Comments:

**14. Do you suffer from migraines or headaches? If so, how often?** (required)

- ○ Yes (Please describe in comment box.)
- ○ No

Additional Comments:

**15. Do you have sensitivity to the following.**

- ○ Sensitivity to lights
- ○ Sensitivity to sounds
- ○ Sensitivity to smells

○ No

Additional Comments:

**16. Do you suffer with dizziness, imbalance, lightheadedness, or true vertigo. If yes, please indicate specific syptoms, decribe symptoms, and include when the symptoms first started.** (required)

○ Dizziness (Please describe in comment box.)
○ Imbalance (Please describe in comment box.)
○ Vertigo/Spinning (Please describe in comment box.)
○ Lightheadedness (Please describe in comment box.)
○ No I do not have any of these symptoms

Additional Comments:

**17. Do you have motion sickness?**

○ Yes - only as a child
○ Yes - as an adult
○ Yes - as a child and continued into adulthood
○ No

Additional Comments:

**18. Have you fallen twice in the last year without injury or once with injury?** (required)

○ Yes - I have fallen. (Please describe the situation or known cause in the comment box.)
○ No

Additional Comments:

**19. Have you smoked tobacco in the last 2 years?** (required)

○ Yes - I use tobacco
○ No - I do not use tobacco

**20. List current prescriptions, vitamins, herbals, and any over the counter medications:**

| | |
|---|---|
| Drug | PLEASE ATTACH SEPARATE SHEET LISTING ALL MEDICATIONS |
| Dosage | |
| Frequency | <NONE SELECTED> <NONE SELECTED> |
| Delivery Method | <NONE SELECTED> |
| Comments | |

Add Medication

**Medication List**

No medications currently entered. Please use the form above to specify the applicable medications.

**21. Please describe any other ear related symptoms or describe any other information you would like the Audiologist to know.** (required)

- ○ other symptoms
- ○ No other symptoms

Additional Comments:

**22. Other reason for this visit. Please add details in the comment box.**

- ○ Failed hearing screening in school and was referred for more testing.
- ○ Failed hearing screening in the doctors office and was referred for more testing.
- ○ I am uncertain why I was scheduled for the appointment.
- ○ Other - I will discuss further when in the office.

Additional Comments: