SCH - Adult Case History Questionnaire

second chance hearing 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: