Hearing Clinic at SUNY Geneseo
Sturges 212
One College Circle
Geneseo, New York 14454
585-245-5332

HEARING CLINIC CASE HISTORY FORM for ADULTS

Name: _____ Date of Birth: _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Gender: ☐ M ☐ F

Address: _____
(Street/Route) (City/State) (Zip)

Telephone Number: _____ ☐ Home ☐ Cell ☐ Work

E-mail Address: _____

Who referred you to the Speech and Hearing Clinic? _____

I. GENERAL MEDICAL INFORMATION

What is the name and address of your physician? _____

_____

List any prescription and non-prescription medications you take regularly. _____

_____

II. HEARING HISTORY

What concerns prompted you to schedule an appointment for a hearing evaluation? _____

_____

_____

Do you have a known hearing loss? Yes No ☐ Left Ear ☐ Right Ear ☐ Both Ears

When did you first become aware of difficulty hearing? _____

Does your hearing seem to fluctuate? Yes No

Does anyone in your family have a hearing loss? Yes No If yes, who? _____

Have you previously had your hearing evaluated? Yes No If yes, where? _____

What did the results reveal? _____

Do you now, or have you ever worn hearing aids? Yes No

If yes, when and where were they purchased? _____

Do you experience ringing or other noises in your ☐ Right Ear? ☐ Left Ear? ☐ Both Ears?

If yes, describe the noise. _____

Do you experience dizziness or vertigo? Yes No Is there a known cause? Yes No

If yes, what is the cause? _____

Have you ever been exposed to noise of high levels (military, recreational, work)? Yes No

If yes, did you or do you wear hearing protection? _____

Do you experience any pain, pressure/fullness or drainage in either ear? Yes No

If yes, which ear? ☐ Right Ear ☐ Left Ear ☐ Both Ears

Do you have a history of ear infections? Yes No

If yes, which ear? ☐ Right Ear ☐ Left Ear ☐ Both Ears

Have you previously had surgery on either ear? Yes No

If yes, please describe._____

Have you ever had an injury to either ear? Yes No

If yes, please describe._____

Have you ever had a head injury? Yes No

If yes, please describe._____

Please tell us anything else you would like us to know about your ears or hearing? _____

_____

_____

III. SELF-ASSESSMENT OF LISTENING DIFFICULTIES (Schow & Nerbonne, 1982))

Please circle the appropriate answer.

Do you experience hearing difficulties:

1. when speaking with one other person? (e.g., at home, at work, with a spouse)	YES	NO	SOMETIMES
2. when talking with a small group of several persons? (e.g., meetings)	YES	NO	SOMETIMES
3. while listening to someone speak in large groups? (e.g., church, lectures)	YES	NO	SOMETIMES
4. when you are in unfavorable listening environments? (e.g., at a noisy party, riding in a car, from a distance)	YES	NO	SOMETIMES
5. when talking on the telephone?	YES	NO	SOMETIMES
6. when listening to television?	YES	NO	SOMETIMES
7. Do others suggest that you have a hearing problem?	YES	NO	SOMETIMES

Date Completed: _____