Ball State University
Audiology Clinic
Adult Case History

Name _____ Birth Date _____ Age _____ Gender ❑ M ❑ F

Audiologist _____ Grad. Clinician _____ Date _____

Referral Source _____

Occupation _____

1. **Reason for Visit:** _____

   _____

2. **Hearing Loss:** ❑ Yes ❑ No Approx year or age of onset: _____

   Which ear: ❑ RT ❑LT ❑ Both Better ear: ❑ RT ❑LT ❑ Unknown

   Hearing loss characteristics: ❑ Rapid onset/changes ❑ Gradual onset/changes ❑ Fluctuating

   Family history: ❑ Yes ❑ No Who: _____

   Situations that cause difficulty: _____

   Remarks: _____

3. **Previous Hearing Evaluation:** ❑ Yes ❑ No

   When / Where: _____

   Results: _____

   Recommendations made: _____

4. **Noise Exposure:** ❑ Yes ❑ No

   Types of noise: ❑ Occupational: _____

   ❑ Recreational: _____

   ❑ Other: _____

   Hearing protection used? ❑ Yes ❑ No Percentage of time: _____

   Remarks: _____

5. **History of Ear Infections:** ❑ Yes ❑ No ❑ RT ❑ LT ❑ Both

   Frequency: _____

   Treatment: ❑ Antibiotics ❑ PE Tubes (# of sets: _____) ❑ Other: _____

6. **Ear Surgery:** ❑ Yes ❑ No ❑ RT ❑ LT

   Date / type of surgery: _____

7. **Tinnitus:** ❑ Yes ❑ No Approx year or age of onset: _____

   ❑ RT ❑ LT ❑ AU / Non-localized ❑ Constant ❑ Fluctuating

   Description: _____

   Concurrent symptoms: ❑ Dizziness ❑ Hearing loss ❑ Other: _____

8. **Dizziness:** ❑ Yes ❑ No ❑ Vertigo ❑ Light headed

   Describe: _____

   Previously evaluated? ❑ Yes ❑ No Where/how: _____

   Successfully treated ❑ Yes ❑ No Where/how: _____

   (If patient reports dizziness, refer to the Dizziness / Balance Case History)

9. **Other Auditory Symptoms:**

   ❑ Aural fullness/pressure (❑ RT ❑ LT) ❑ Hypersensitivity to loud sounds

   ❑ Otalgia (❑ RT ❑ LT) Describe: _____

   ❑ Other: _____

10. **Hearing Instruments:** ❑ Currently uses ❑ Previously used ❑ Recommended, never used

    Ear fit: ❑ RT ❑ LT ❑ AU Style: _____

    Perceived benefit: _____

    Comments: _____

11. **General Health:**

    ❑ Good ❑ Other: _____

    Current medications: _____

    _____

    _____

12. **Comments / Additional Information:**

    _____

    _____

    _____

Tinnitus Handicap Inventory

Name _____

Date _____

The purpose of the scale is to identify the problems your tinnitus may be causing you. Circle "Yes," "Sometimes," or "No" for each question. Do not skip a question.

1. Because of your tinnitus is it difficult to concentrate?	Yes / Sometimes / No
2. Does the loudness of your tinnitus make it difficult for you to hear people?	Yes / Sometimes / No
3. Does your tinnitus make you angry?	Yes / Sometimes / No
4. Does your tinnitus make you feel confused	Yes / Sometimes / No
5. Because of your tinnitus do you feel desperate?	Yes / Sometimes / No
6. Do you complain a great deal about your tinnitus?	Yes / Sometimes / No
7. Because of your tinnitus do you have trouble falling to sleep at night?	Yes / Sometimes / No
8. Do you feel that you cannot escape your tinnitus?	Yes / Sometimes / No
9. Does your tinnitus interfere with your ability to enjoy social activities (such as going out to dinner, to the movies)?	Yes / Sometimes / No
10. Because of your tinnitus do you feel frustrated?	Yes / Sometimes / No
11. Because of your tinnitus do you feel that you have a terrible disease?	Yes / Sometimes / No
12. Does your tinnitus make it difficult for you to enjoy life?	Yes / Sometimes / No
13. Does your tinnitus interfere with your job or household duties?	Yes / Sometimes / No
14. Because of your tinnitus do you find that you are often irritable?	Yes / Sometimes / No
15. Because of your tinnitus is it difficult for you to read?	Yes / Sometimes / No

16. Does your tinnitus make you upset?	Yes / Sometimes / No
17. Do you feel that your tinnitus problem has placed stress on your relationship with members of your family and friends?	Yes / Sometimes / No
18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes / Sometimes / No
19. Do you feel that you have no control over your tinnitus?	Yes / Sometimes / No
20. Because of your tinnitus do you often feel tired?	Yes / Sometimes / No
21. Because of your tinnitus do you feel depressed?	Yes / Sometimes / No
22. Does your tinnitus make you feel anxious?	Yes / Sometimes / No
23. Do you feel that you can no longer cope with your tinnitus?	Yes / Sometimes / No
24. Does your tinnitus get worse when you are under stress?	Yes / Sometimes / No
25. Does your tinnitus make you feel insecure?	Yes / Sometimes / No

Ball State University Speech and Audiology Clinic – Family Medical History Form

Patient: _____ Date: _____ Birthdate: _____ Sex: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: ( ) _____ Other Phone: ( ) _____ Email: _____

Primary Care Physician: _____ City: _____

Maternal Ethnicity of Patient: Paternal Ethnicity of Patient: _____

Person Completing this Form *(if not patient):* _____ Relation to patient: _____

Reason for Appointment: _____

Please indicate if the patient or any relatives (including at least 3 generations) currently experience or have experienced the listed symptoms or conditions. Please provide additional information if possible and note which relative (e.g., maternal grandmother) when applicable. Information on family health can be useful in understanding potential causes for hearing, speech or language difficulties or other health issues. While some symptoms (e.g., miscarriages or fainting spells) may seem irrelevant, certain combinations of symptoms may signal an underlying condition that is related to the patient's primary concern.

Otologic and Hearing problems: **Relationship/Comments:**

Patient	Relative		
☐	☐	Hearing Loss Present at Birth, Childhood, or Young Adulthood	_____
☐	☐	Hearing Loss, Any Age of Onset	_____
☐	☐	Vertigo/Dizziness/Balance problems	_____
☐	☐	Other	_____

Vision Problems:

Patient	Relative		
☐	☐	Premature and/or Progressive, Significant Vision Loss	_____
☐	☐	Night Blindness	_____
☐	☐	Tunnel Vision	_____

Learning Disabilities/Developmental Delays:

Patient	Relative		
☐	☐	Cognitive Function Impairment (Mental Retardation)	_____
☐	☐	Speech/Language Delay	_____
☐	☐	Motor Delay	_____
☐	☐	Learning Disability of Unknown Cause	_____
☐	☐	Autistic Spectrum Disorders	_____
☐	☐	Other	_____

Neurological or Cardiovascular Concerns:

Patient	Relative		
☐	☐	Seizures	_____
☐	☐	Fainting	_____
☐	☐	Tremors	_____
☐	☐	Heart Defect	_____
☐	☐	Heart Attack	_____
☐	☐	Irregular Heartbeat	_____

LAS 12/10

Patient	Relative		
☐	☐	Sudden Death (unexplained)	
☐	☐	SIDS	

Musculoskeletal

☐	☐	Unusual Stature	
☐	☐	Craniofacial or Oral Abnormalities	
☐	☐	Cleft Palate/Lip	
☐	☐	Ear Anomalies	
☐	☐	Arthritis	
☐	☐	Frequent Broken Bones	

Kidney

☐	☐	Kidney Malformation	
☐	☐	Kidney Disease	
☐	☐	Blood in Urine	

Pigmentation

☐	☐	Heterochromia (eyes of different color or a multi-colored eye)	
☐	☐	Hair (early graying, white patches)	
☐	☐	Vitiligo	
☐	☐	Café au Lait Spots	

Reproductive/Pregnancy Concerns:

Patient	Relative		
☐	☐	Stillbirth	
☐	☐	Miscarriage	
☐	☐	Early Menopause	
☐	☐	Consanguinity (interfamily relationship)	
☐	☐	Infertility	

Endocrine:

Patient	Relative		
☐	☐	Diabetes	
☐	☐	Thyroid Disorder (enlarged thyroid - goiter)	

Genetic Disorders & Syndromes:

Patient	Relative		
☐	☐	Stickler Syndrome	
☐	☐	Usher Syndrome	
☐	☐	Branchio-oto-renal Syndrome	
☐	☐	Pendred Syndrome	
☐	☐	Neurofibromatosis type II	
☐	☐	Mitochondrial Disorders	
☐	☐	Alport Syndrome	
☐	☐	Waardenburg Syndrome	
☐	☐	Long QT Syndrome/Jervell Lange-Nielsen	

Genetic Disorders & Syndromes *(continued)*: **Relationship/Comments:**

Patient	Relative		
☐	☐	Pierre-Robin Sequence	
☐	☐	Treacher Collins Syndrome	
☐	☐	Connexin 26 Deafness	
☐	☐	Other Syndromes or Chromosomal Abnormalities	

Has a family member ever had an evaluation by a geneticist? ☐ yes ☐ no

Please make any additional comments in the space provided below.

LAS 12/10

Medications and Supplements Form
Ball State Audiology Clinic

Name: _____ Date of Birth: _____ Phone Number:_____ Today's Date: _____

Please fill in all medications you take, whether regularly or as needed. Fill in as many categories as possible. If you already have a medication list that includes all of the information below, please feel free to bring that list to the appointment instead. Information on medications can be useful in understanding potential causes for hearing difficulties or other health issues. While some medications or supplements may seem irrelevant, certain combinations of medications and symptoms may relate to your hearing or balance problem(s).

Name of Medications or Supplements	Dosage	How often you take the medication?	Reason for taking	Date Started

Please list allergies (medication or other): _____
_____
_____