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: _______________________________________________________________________
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:**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Relative</th>
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<tbody>
<tr>
<td>☐</td>
<td>☐ Hearing Loss Present at Birth, Childhood, or Young Adulthood</td>
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<td>☐</td>
<td>☐ Hearing Loss, Any Age of Onset</td>
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<td>☐</td>
<td>☐ Vertigo/Dizziness/Balance problems</td>
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<td>☐</td>
<td>☐ Other</td>
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**Vision Problems:**

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<th>Patient</th>
<th>Relative</th>
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<tr>
<td>☐</td>
<td>☐ Premature and/or Progressive, Significant Vision Loss</td>
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<td>☐</td>
<td>☐ Night Blindness</td>
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<td>☐</td>
<td>☐ Tunnel Vision</td>
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**Learning Disabilities/Developmental Delays:**

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<th>Patient</th>
<th>Relative</th>
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<tr>
<td>☐</td>
<td>☐ Cognitive Function Impairment (Mental Retardation)</td>
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<td>☐</td>
<td>☐ Speech/Language Delay</td>
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<td>☐</td>
<td>☐ Motor Delay</td>
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<td>☐</td>
<td>☐ Learning Disability of Unknown Cause</td>
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<td>☐</td>
<td>☐ Autistic Spectrum Disorders</td>
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<td>☐</td>
<td>☐ Other</td>
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**Neurological or Cardiovascular Concerns:**

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<tr>
<th>Patient</th>
<th>Relative</th>
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<tr>
<td>☐</td>
<td>☐ Seizures</td>
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<td>☐</td>
<td>☐ Fainting</td>
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<td>☐</td>
<td>☐ Tremors</td>
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<td>☐</td>
<td>☐ Heart Defect</td>
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<td>☐ Heart Attack</td>
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<td>☐</td>
<td>☐ Irregular Heartbeat</td>
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</table>
### 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:
- Stillbirth
- Miscarriage
- Early Menopause
- Consanguinity (interfamily relationship)
- Infertility

### Endocrine:
- Diabetes
- Thyroid Disorder (enlarged thyroid - goiter)

### Genetic Disorders & Syndromes:
- 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):

<table>
<thead>
<tr>
<th>Patient</th>
<th>Relative</th>
<th>Relationship/Comments:</th>
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<tr>
<td></td>
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<td>Pierre-Robin Sequence</td>
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<td>Treacher Collins Syndrome</td>
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<td></td>
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<td>Connexin 26 Deafness</td>
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<td>Other Syndromes or Chromosomal Abnormalities</td>
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Has a family member ever had an evaluation by a geneticist?  ☐ yes  ☐ no

Please make any additional comments in the space provided below.

________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________
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).

<table>
<thead>
<tr>
<th>Name of Medications or Supplements</th>
<th>Dosage</th>
<th>How often you take the medication?</th>
<th>Reason for taking</th>
<th>Date Started</th>
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Please list allergies (medication or other): ____________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

KRA 9/13