HearSay Services of Delaware, Inc.

ADULT HISTORY FORM

Name_____ M__ F___

Birth date_____ Today's Date _____

Phone (H) _____ (W) _____ (Cell)

_____ e-mail_____

Address_____
City State

Referent_____ Insurance _____

Presenting Problem_____

How did you hear about us:
Newspaper Friend, word of mouth, relative , Premier health newsletter
Health fair screening , Letter of invitation , Doctor referral , Web site ,
Post Card , VIP Newsletter , Other_____

Hearing Sensitivity:
Do you have difficulty hearing or understanding in the Right or Left ear? Neither .
Do you have an ear you feel is worse? Right Left
Was the hearing loss GRADUAL or SUDDEN in onset?
If gradual, how long has it been getting worse? _____
If sudden, what were you doing just prior to it getting worse? (illness, cancer treatment, car accident, etc.)_____
Have you had your hearing tested before? yes no
Where? _____ Date_____
(Circle one) Normal to some degree Hearing loss to some degree

Tinnitus:
Do you have noises in your ears? yes no
Is the sound in the right or left ear?
Describe the sound: _____
Is the sound constant or does it come and go ?
Does the noise keep you from falling asleep at night? yes , no
On a scale of 1 (no impact) to 10 (ruined), how does it affect your life?

Hearing Instrument Use:
Have you ever worn hearing aids before? yes no If so, which ear? right left both Behind the ear ___ In the ear ___ In the canal: ___
Make and Model: _____ Date purchased_____
Where purchased_____
Consistency of use (ex: daily, on special occasions, always, etc.):
_____
Satisfaction: Good ___ Fair ___ Poor___

Balance:
Do you feel off balance lightheaded a spinning sensation ? No .
When was the onset? _____
Do you feel this constantly or does it come and go ?
If it comes and goes, how long does the feeling last?_____
What initiates the feeling?_____

Aural Fullness:
Do you have feelings of pressure or fullness in either ear? No .
If yes, how often do you experience this feeling?_____

Trauma:

Have you ever had a severe injury to your head? yes no

Have you ever had: Right ear Left ear
Punctured eardrum
Ear surgery
Ear pain
Ear infections
Ear drainage

Explain any of the above_____
Noise exposure:
Have you ever been exposed to: gunfire , firecrackers , explosions , power tools ,
occupational noise , lawn mower , other_____
If yes to any of the above, do you use hearing protection? yes no
Were you in the military? yes no

Family History:
Does any member of your family have a hearing loss? yes no ?
If yes, who _____
Do you know the cause of their hearing loss? yes no
_____

Medications:
Have you ever taken a medication that your doctor said may have an effect on your hearing?_____
Have you ever taken an anticancer (chemotherapy) drug? yes no
If yes, was your hearing monitored during that time? yes no Please list current and past medications if known
_____

Communicable Diseases:
Tuberculosis (TB)-Please check all boxes that currently apply:
History
active TB or history of recent TB (even if on meds)
Signs and Symptoms

cough >2 weeks
fever and/or chills and/or night sweats
weight loss>10 pounds
immune compromised (HIV, cancer, chronic illness)

Measles:

Have you ever had the measles?	No	Yes
Have you received the measles vaccine?	No	Yes
If no, been exposed with last 2 weeks?	No	Yes

Chickenpox:

Have you ever had the chickenpox?	No	Yes
Have you received the chickenpox vaccine?	No	Yes
If no, been exposed in the last 2 weeks?	No	Yes

Additional comments:

_____

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Thank you for choosing HearSay Services of Delaware!