Indiana University Audiology Clinic
2631 East Discovery Parkway Bloomington, IN 47408

Group Home – Adult Case History **Date:_____**

Name:_____ DOB_____

Length of Residence_____ Functional Level_____

Referred by_____ Physician_____

Guardian/POA_____

Address_____

Phone Number_____

Form completed by :_____

Hearing Loss History and Present Status

A. Why are you here?_____
B. Is hearing loss suspected?_____Why?_____
C. Which is better ear? Right____ Left_____
D. Is hearing status the same from day to day? _____
E. Is sign language used? _____ If so will you need an interpreter during your visit? ____ (if the answer is yes, please call us at 812-855-7439) we will provide one for the client.

Medical History (check all that apply

□ Head injury with unconsciousness/when:_____
□ Ear pain (□Right □Left □Both) Onset/Describe:_____
□ Discharge from the ear (□Right □ Left □ Both) Onset/Describe:_____
□ Fullness or pressure (□Right □Left □ Both) Onset/Describe: _____
□ Ear deformity (□Right □Left □ Both) Onset/Describe: _____
□ Visible congenital or traumatic deformity of the ear (□ Right □ Left □ Both) Onset/Describe: _____
_____
□ Ear wax accumulation (□Right □ Left □ Both) Onset/Describe: _____
□ Foreign Body in ear (□ Right / □ Left□ Both) Onset/Describe: _____

History of Ear Infections: □Yes □No
Ear:□ Right □Left □Both Age of Onset:_____ Age of last infection:_____

Treatment: _____
Remarks/Describe:_____

Ear Surgery: □Yes □ No
Ear: □Right □Left □Both Type/Date of Surgery: _____
Remarks/Describe:_____

Noise Exposure (On the job, farm equipment, fireworks)_____

Any Known Syndromes?_____

Vestibular/Balance History: □Yes □ No
Vertigo: □ Yes □ No
Other vestibular symptoms: □ Light-Headedness □ Spinning sensation □ Unsteadiness □ Imbalance Accompanying Symptoms: □ Nausea □ Change in or onset of tinnitus □ fluctuating hearing loss
□ Fullness or Pressure □ Other:_____

Two or more falls in the past year or once with an injury: □ Yes □ No
Do you take Vitamin D? □ Yes □ No
Vestibular/Balance Treatment(s):_____
Remarks/Describe:_____

Hospitalizations/Surgeries (Date/Type): _____
_____

Medical Conditions:
□ Diabetes □ Cancer □ Depression □ Multiple Sclerosis □ Heart Disease □ Vascular Conditions
□ Meningitis □ Autoimmune Disease□ Head injury □ Psychiatric □ HIV/AIDS □ Migraines
□ Neurologic conditions □ Visual Issues □ Other _____

Tobacco use in the last two years: □ Yes □ No
Type of tobacco product: □ cigarettes/cigars/pipes □ electronic-cigarette □ chewing tobacco

Alcohol Use: □ Yes □ No Frequency: _____
Recreational drug or marijuana use: □ Yes □ No Frequency: _____

Current Medications: (Include name, dosage and frequency)

Name	Dosage	frequency

Audiological History

A. Any known family history of hearing loss occurring before 50 years of age?_____
B. Previous hearing tests and known results?_____
C. Hearing aid use in the past? _____ Currently wear them?_____
   Purchased where?_____

Communicative Abilities

A. Type of communication (verbal, gestures, sign language, etc)_____
B. How well are simple instructions and commands understood?_____
   _____
C. Mark the tasks that could be completed:

   Repeating words_____ Pointing to pictures_____ Identifying body parts____

   Placing a peg in a board____ Dropping a block in a bucket. _____

D. Would a negative reaction be anticipated towards:

   Strangers_____ Wearing headphones_____ Examining ears_____

   Conditioning to a simple tasking_____