INDIANA UNIVERSITY

Audiology Clinic, 2631 East Discovery Parkway Bloomington, IN 47408

Adult Case History-Returning patient
Date: _____

Name:_____ Age:_____ Birthdate:____-____-____

Referral Source:_____ Primary Care Physician:_____

1.Hearing:

Change in hearing? ☐ Yes ☐ No ☐ Unsure_____

_____

Change in balance? ☐ Yes ☐ No ☐ Unsure_____

Noises in ears (tinnitus) or changes in tinnitus? ☐ Yes ☐ No ☐ Unsure_____

2. Medical History: (check all that apply)

☐ Ear pain (☐ Right ☐ Left ☐ Both) Onset/Describe:_____

☐ Discharge from the ear (☐ Right ☐ Left ☐ Both) Onset/Describe:_____

☐ Fullness or pressure (☐ Right ☐ Left ☐ Both) Onset/Describe: _____

Two or more falls in the past year or once with an injury: ☐ Yes ☐ No

Vestibular/Balance Treatment(s):_____

_____

Do you take Vitamin D? ☐ Yes ☐ No

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 and supplements (include dosage, frequency and route):

Name	Dosage	Frequency	Route

Allergies: _____

Hearing aid information:

_____
_____
_____
_____
_____
_____

Client/Guardian Signature:_____**Date:**_____

Form date: 5/17/2017