HEAR MICHIGAN INC.
Professional Audiology Services

Adult Case History

NAME_____ DATE_____

1. Do you feel that you have a hearing problem? Yes No
   If yes, for how long?_____

2. Do you hear better out of one ear than the other? Yes No
   If yes, which ear is your better ear? Right Left

3. In which listening situations do you have difficulty hearing? (circle all that apply)
   One-on-one conversations, groups, work, worship services, meetings, restaurants, TV, telephone, theatres, in the car, other_____

4. Have you had your hearing tested before? Yes No
   If yes, when? _____

5. Have you ever worn hearing aid(s)? Yes No
   If yes, for how long? _____

6. Have you experienced any pain or drainage in the past 90 days? Yes No

7. Do you have chronic noise in your ears, called tinnitus? Yes No
   If yes, please describe_____

8. Have you experienced any dizziness or loss of balance within the past 90 days that you cannot relate to a specific cause? Yes No

9. Have you ever had a serious illness that affected your hearing? Yes No
   If yes, please describe_____

10. Have you ever been exposed to loud noise? (circle all that apply) Yes No
    Farm equipment, power tools, machinery, lawn mowers, chain saws, firearms, snow blowers, other (please describe)_____

11. Do you have a history of hearing loss in your family? Yes No
    If yes, please describe_____

12. Have you ever had any surgery on your ear(s)? Yes No
    If yes, please describe_____