Autumn Oak Speech, Voice & Hearing, PLLC
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CASE HISTORY: ADULT HEARING

Patient Information

Today's Date: _____

Patient Name: _____

Patient Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____+___

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Gender (Circle One): Male Female

Patient Occupation or

Grade in School: _____

Patient Employer or Name of School: _____

Parent/Caregiver or Spouse's Name: _____

Single _____ Married_____ Divorced_____ Widowed_____

How did you hear about us? (Circle One):

Newspaper Other Advertisement Insurance Company Internet Other: _____

Who may we thank for referring you to our office today?

Friend: _____

Doctor: _____

Person Responsible for Payment: _____

CONCERNS: Describe the speech and/or hearing problems briefly. Is this the only problem?

_____

HISTORY OF HEARING PROBLEM/MEDICAL DIAGNOSIS:

Age of onset: _____ Conditions of onset:

What attempts have been made to treat this problem?

When? _____ Results of this treatment?

Describe any circumstances that change the symptoms:

Do you consider this problem mild, moderate, or severe (Circle one) or other (Explain):

Is this problem interfering with your educational, social or vocational plans? Please explain if you answered "yes":_____

Do people have difficulty understanding you when you talk to them?

If so, do you know why?

Have you ever "lost your voice?" _____. If yes, describe circumstances and duration

_____
_____
Was English your first language? _____Other languages spoken:
_____

MEDICAL HISTORY:

Personal physician: _____
Others: _____
Were you late to talk or walk? _____ at what age: _____
Did you have any speech, language or swallowing problems as a child?
_____
Any history of: Excessive colds _____, allergies _____, sinus trouble _____,
asthma _____, sore throats _____, upper respiratory infections _____,
pneumonia _____, laryngitis _____, thyroid problems _____, swallowing
difficulties _____, wet vocal quality after eating/drinking _____.

Please list below all illnesses, injuries and operations:
Type: Age: Fever? Complications: Treatments: Physician
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
Tonsils and adenoids in _____ out _____

List all present physical disabilities:
_____

Current medications: _____
_____
_____

Estimate of your current physical health:
_____

Has your vision ever been tested? _____ Do you wear glasses? _____

Has your hearing ever been tested? _____ Do you wear a hearing aid? _____
Do you think you may have a hearing problem?
_____

SCHOOL HISTORY:

Educational Level: Elementary _____ Junior High _____ Senior High _____
College _____
Degree _____ Vocational _____ Other
_____

SOCIAL HISTORY:

Hobbies/Sports: _____

Leisure time activities: _____

Group memberships: _____

FAMILY HISTORY:

Is there any family history of chronic illness, allergies, speech problems, hearing problems, swallowing problems, or other conditions? Please list all and describe conditions.

_____
_____
_____
_____
_____

Additional Comments: