



**MONTCLAIR
STATE
UNIVERSITY**

**Department of Communication Sciences and Disorders
Hearing & Balance Center
Voice: 973-655-7752
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ADULT CASE HISTORY

NAME: _____ DATE: _____

DATE of BIRTH: ___/___/___ TEL # _____ CELL # _____

ADDRESS: _____
(Include street, city, state and zip code)

EMAIL ADDRESS: _____ OCCUPATION: _____

MARITAL STATUS: _____ PRIMARY LANGUAGE: _____

What brings you to the clinic today?

What would you like to accomplish at the MSU Hearing Center?

Please answer the following questions. (CIRCLE ANSWERS)

1. Do you have hearing problems? YES NO
Which ear? LEFT RIGHT BOTH

2. Has the hearing loss been? GRADUAL SUDDEN FLUCTUATING

3. Do you hear better in one ear? YES NO
Which ear? LEFT RIGHT

4. Have you been seen previously for your hearing problem? YES NO
Who? _____ When? _____

5. Do you wear a hearing device? YES NO
Which ear? LEFT RIGHT BOTH

Type of Device _____ How long have you worn them? _____

Are you interested in wearing one? YES NO

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855 Valley Road, Clifton, NJ 07013**

NOTES:

6. Do you have noises in your ear(s)? YES NO
Which ear? LEFT RIGHT BOTH
How often do you hear it? CONSTANTLY OCCASIONALLY RARELY

DESCRIBE:

7. Do you ever have a feeling of fullness or stuffiness in your ears? YES NO

DESCRIBE:

8. Do you have ear pain? YES NO
Which ear? LEFT RIGHT BOTH

DESCRIBE:

9. Do you ever experience facial numbness, weakness or tingling? YES NO

How recently? _____

DESCRIBE:

10. Are you dizzy, unsteady, or off balance? YES NO

DESCRIBE:

Is your dizziness accompanied by:

Nausea?	YES	NO
Vomiting?	YES	NO
Noise in your ears?	YES	NO

11. Have you ever been exposed to excessively loud noise? YES NO

How recently? _____

DESCRIBE:

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12. Does anyone in your family have a hearing loss? YES NO

DESCRIBE:

13. Do you get ear infections? YES NO

NOTES:

14. Are you currently taking medication? YES NO

LIST:

15. Have you ever been treated with IV antibiotics or chemotherapy?
YES NO

DESCRIBE:

16. Do you have any chronic illnesses?

LIST:

17. Have you ever had ear surgery? YES NO

DESCRIBE:

18. Have you ever had head, neck, or ear surgery? YES NO

DESCRIBE:

19. Have you received any communication or dizziness therapy in the past or current time?
YES NO

DESCRIBE:

20. Have you served in the military? YES NO

21. Please list your hobbies?

22. Who may we thank for this referral?

PLEASE USE THIS SPACE TO PROVIDE US WITH ANY OTHER ADDITIONAL INFORMATION THAT MAYBE HELPFUL

Name of Person Completing this form _____

Signature: _____ Date: _____