Parrs Pro Hearing Services
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Adult Case History Form

Parr's Pro Hearing
SERVICES, INC
DOCTORS OF AUDIOLOGY-BOARD CERTIFIED
AUDIOLOGY AND HEARING AIDS

Patient Name: _____ **Date of Completion:** _____

Date of Birth: _____ **Gender:** _____ **Primary Language:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Race: ☐ White ☐ African-American ☐ Asian ☐ American Indian ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino

Current Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed

☐ Stay at Home Parent ☐ Student

Current Employer: _____ **Position:** _____

Highest Level of Education: _____

Do you currently use recreational drugs? ☐ Yes ☐ No

If yes, what drugs: _____

How often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months? ☐ Yes ☐ No

If yes, how often have you used a tobacco product in the past 24 months? _____

If yes, what do you use: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless ☐ Other: _____

If yes, amount of use per day: _____

Do you currently drink alcoholic beverages? ☐ Yes ☐ No

If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Medical History

Current Medications:

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Allergies (foods, medications, plastics, etc.): _____

_____

Other illnesses, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence: _____

_____

Have you been immunized? ☐ Yes ☐ No

If yes, for what illnesses or diseases: _____

Have you experienced any of the following major medical conditions (please check all that apply):

- ☐ **Arthritis**
- ☐ **Autoimmune**
- ☐ **Blood Disorders**
- ☐ **Cancer**
  - ☐ **Chemotherapy**
  - ☐ **Radiation**
- ☐ **Chicken Pox**
- ☐ **COVID-19**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Diphtheria**
- ☐ **Encephalitis**
- ☐ **Fatigue**
- ☐ **Genetic Disorders**
- ☐ **Headaches**
  - ☐ **Migraines**
- ☐ **Head Injury**
- ☐ **Heart Problems**
- ☐ **High Blood Pressure**
- ☐ **High Fevers**
- ☐ **Influenza**
- ☐ **Kidney Disease**
- ☐ **Malaria**
- ☐ **Measles**
- ☐ **Meningitis**
- ☐ **Mumps**
- ☐ **Scarlet Fever**
- ☐ **Shingles**
- ☐ **Stroke**
- ☐ **TMJ**
- ☐ **Typhoid**
- ☐ **Vascular Problems**
- ☐ **Other:** _____

Please check all medical symptoms or conditions that apply:

- **Eye problems (i.e.: blurred or double vision, pain):** ☐ Yes ☐ No
- **Nose, throat, or mouth problems (i.e.: trouble swallowing, nose bleeds, dental issues):** ☐ Yes ☐ No
- **Cardiovascular issues (i.e.: hypertension, chest pain, swelling, palpitations):** ☐ Yes ☐ No
- **Respiratory issues (i.e.: shortness of breath, cough, wheezing):** ☐ Yes ☐ No
- **Gastrointestinal issues (i.e.: nausea, vomiting, weight changes, diarrhea, pain):** ☐ Yes ☐ No
- **Musculoskeletal issues (i.e.: joint pain, swelling, recent trauma):** ☐ Yes ☐ No
- **Neurological symptoms (i.e.: numbness, headaches, tingling, seizures, muscle weakness):** ☐ Yes ☐No
- **Psychiatric issues (i.e.: depression, anxiety, compulsions):** ☐ Yes ☐ No
- **Endocrine symptoms (i.e.: frequent urination, hot flashes):** ☐ Yes ☐ No
- **Hematologic/lymphatic symptoms (i.e.: bleeding gums, bruising, swollen glands):** ☐ Yes ☐ No
- **Allergic/immunologic symptoms (i.e.: hives, asthma, itching, immune deficiency):** ☐ Yes ☐ No

Comments related to Review of Symptoms above: _____

Audiologic History

Do you experience hearing loss? ☐ Yes ☐ No

If so, which ear? ☐ Right ☐ Left ☐ Both

If you experience hearing loss, which best describes it? ☐ Gradual ☐ Fluctuating ☐ Sudden

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Have you ever experienced dizziness, unsteadiness, imbalance, or vertigo? ☐ Yes ☐ No

If yes, are you feeling dizzy today? ☐ Yes ☐ No

If yes, please describe: _____

Frequency of occurrence: _____

If yes, is it accompanied by ☐ nausea ☐ ringing or noises in your ear ☐ hearing loss ☐ visual disturbances

Have you fallen within the past 12 months? ☐ Yes ☐ No

If yes, how many falls have you experienced in the 12 months? _____

If you have fallen, have you been injured? ☐ Yes ☐ No

Please describe your injury: _____

Do you experience visual difficulties or disturbances? ☐ Yes ☐ No

If yes, please describe: _____

Do you currently take a Vitamin D supplement? ☐ Yes ☐ No

Have you ever had a hearing test? ☐ Yes ☐ No

If so, when: _____

Which ear do you typically use to talk on the telephone: ☐ Right ☐ Left

Have you ever worn or tried a hearing aid or amplifier? ☐ Right ear ☐ Left ear ☐ Both ears

What type and/or style of hearing aid or amplifier: _____

Please describe your experience: _____

Please check all of the medical conditions that apply:

☐ **Developmental disorder/delay**
If checked, please explain: _____

☐ **Ear deformity**
If checked: ☐ Right ear ☐ Left ear ☐ Both ears

☐ **Ear drainage**
If checked: ☐ Right ear ☐ Left ear ☐ Both ears

☐ **Ear pressure**
If checked: ☐ Right ear ☐ Left ear ☐ Both ears

☐ **Ear pain**
If checked: ☐ Right ear ☐ Left ear ☐ Both ears

☐ **Family history of hearing loss**
If checked, who is the family member: _____

☐ **History of ear infections**
If checked: ☐ Right ear ☐ Left ear ☐ Both ears

☐ **History of earwax buildup**

☐ **History of noise exposure**
☐ **Occupational** ☐ **Recreational** ☐ **Military** ☐ **Do You Use Hearing Protection**

☐ **Previous ear surgery**
If checked: ☐ Right ear ☐ Left ear ☐ Both ears
If so, when: _____

☐ **Tinnitus/ringing/noises in ears**
If checked: ☐ Right ear ☐ Left ear ☐ Both ears
☐ **Intermittent** ☐ **Constant** ☐ **Pulsed** ☐ **Single sound** ☐ **Multiple sounds**
☐ **Hyperacusis (Sensitivity to Loud Sounds)**

☐ **Other (please describe): _____**