USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

Hearing Clinic
(813) 974-8804
(813) 974-0822 - FAX

Case History Form for Adults – Audiology

Please describe in your own words, your hearing difficulty:

_____

_____

_____

Date form completed: _____ File #_____

IDENTIFICATION

Patient Name: _____ Mr. Mrs. Miss Ms. Dr.
Last First Middle (circle one)

Ethnicity (optional): African American □ Asian/Pacific Islander □ Caucasian □
Hispanic □ Native American □ Other □_____

Date of Birth: _____ Age: _____ Gender (optional) M or F

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Occupation: _____ Place of Employment: _____Phone: _____

Spouse's Name:_____ Spouse's Date of Birth _____

Spouse's Occupation _____ Spouse's Phone: _____

Language(s) spoken by patient: _____ Primary language spoken in home_____

Primary Care Physician: _____

Address: _____ Phone: _____
Street City State Zip

Referred by: _____
Name Address

Reason for referral: _____

Emergency contact: _____ Relation: _____Phone:_____

Where did you learn about our services? _____

Person Completing Questionnaire: _____ Relation to Patient_____

HEARING HISTORY

Is there a history of hearing loss in the family? Yes □ No □ If yes, explain:_____

_____

Do you have a history of □ Ear Drainage □ Ears Ringing □ Dizziness □ Ear Infections □ Earaches
□ Air Bag Deployment □ Head Trauma

Describe any associated problems that occur due to your hearing difficulties:_____

_____

When and by whom were your hearing difficulties first noticed?_____

Was the hearing problem (circle one) sudden, fluctuating, or progressive?

Is your hearing better in one ear? Yes □ No □ If yes, which ear is the better ear? Right □ Left □

In your opinion, what is the cause of your hearing difficulties?_____

Has your hearing ever been evaluated before? Yes □ No □

If yes, when?_____ Where?_____

What were the findings & recommendations?_____

HEARING AID HISTORY

Have you ever worn a hearing aid? Yes □ No □ If no, proceed to **Noise History** section

If yes, how many years have you worn hearing aids?_____

Are you currently wearing hearing aids? Right ear □ Left ear □ Both ears □

Where did you purchase these hearing aids?_____

Are you pleased with their performance? Yes □ No □

If no, explain any problems you have:_____

_____

_____

NOISE HISTORY

Have you ever been in the armed services? Yes □ No □ How long?_____ What branch?_____

Duties included:_____

Have you ever been exposed to loud noises (i.e., mechanical noise, gun blasts, firecrackers, etc.)? Y N

If yes, please explain any current or previous hobbies, activities, or occupations that may have exposed you to loud noises:_____

_____

Are you bothered by loud noises? Yes □ No □ If yes, please explain:_____

_____

_____

MEDICAL HISTORY

Present physical condition (please circle): (Excellent) 1 2 3 4 5 (Poor)

Please describe any significant health problems you have experienced to include: □ Stroke □ Cancer
□ Heart Attacks □ Headaches □ Seizures □ Mumps □ Meningitis □ Measles

□ Kidney Problems □ Diabetes □ Other:_____

List accidents, injuries, or surgeries (include date of occurrence, seriousness, hospitalization, etc.)

_____

_____

_____

Are you under the care of a specialist? Yes □ No □

If yes, state name (first and last) and specialty :_____

Are you taking any prescribed medications? Yes □ No □

Are you taking over-the-counter medications? Yes □ No □

If yes, please list (include dosage and reason)_____

_____

Have you ever taken a medication that was harmful to your hearing? Yes □ No □

Have you ever taken recreational drugs? Yes □ No □

If yes, please describe:_____

_____

Please include any other information that might help us:_____

_____

_____

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Client/Patient Authorization regarding Research Studies, Mode of Communication and Educational Use of Recorded Sessions

Client/Patient's Name:_____

Participation in research projects:

Clients/patients may be asked by researchers in the Department if they would be interested in participating in a research study pertaining to their condition. When contacted, clients will be given an opportunity to review information about the study in order to decide whether or not they wish to participate. **Participation in any research study is always optional and will not affect the clinical care delivered to the client. Clients/patients who do not wish to be contacted regarding opportunities to participate in research may opt out at any time by contacting the clinic or by checking the statement below.** Initials_____

___ Please do NOT contact me with opportunities to participate in research

Electronic communication and transmission of service related information:

Authorization is given to the Speech, Language, Hearing Center of the Department of Communication Sciences and Disorders, University of South Florida, 4202 E. Fowler Ave., Tampa, Florida 33620-8150, to communicate with me via **email, telephone (voice/text) and/or fax,** regarding therapy and/or assessment for the above named client. I acknowledge that the Speech, Language, Hearing Center of the Department of Communication Sciences and Disorders cannot be responsible for non-secured communication. Initials_____

Acknowledgement of the recording of sessions (audio and video):

The University of South Florida Department of Communication Sciences and Disorders operates a clinical facility primarily for the training of future professionals in Speech-Language Pathology, Audiology, and Aural (Re)Habilitation. All clients/patients seen in the clinic for diagnostic and therapeutic services must agree to the recording of sessions. Recordings may be reviewed and used by faculty, staff and students as part of a client/patient's plan of care, as part of a research project and/or to facilitate instructional objectives for students enrolled in the program. Appropriate safeguards related to privacy and confidentiality will be utilized for the use and storage of such recordings and this specific authorization regarding the recordings is attached below and must be signed by each patient.

"I understand the above and hereby release to the University of South Florida Department of Communication Sciences and Disorders, the right to make audio and video recordings or to photograph said person in any and all phases of the educational or remedial process and to put the audio and video recordings or photographs to any legitimate educational or training uses. All recordings, photographs and their reproductions shall remain the property of the Department of Communication Sciences and Disorders of the University of South Florida. It is further agreed that in the event the Department of Communication Sciences and Disorders of the University of South Florida or its assigns shall become a party defendant to litigation by said persons as a result of the legitimate use of said audio and video recordings, photographs, and/or descriptive literature or sound tracks, (I/We) shall hold harmless and indemnify it or its assigns from any judgment which may be entered against it or its assigns."

Signature:_____ Date:_____
Patient