

Confidential Case History Form

Name:

Date of Birth:

SSN:

Address:

Phone: HM-

WK:

FAX:

EMAIL:

Ear Health History

Describe any medical problems you have had with the health of your ears:

Check all that apply and describe details in comment section:

<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Ear drainage	<input type="checkbox"/>	Perforated eardrum	<input type="checkbox"/>	Ear Surgery
<input type="checkbox"/>	Other Medical Conditions	<input type="checkbox"/>	Ear surgery	<input type="checkbox"/>	Other:	<input type="checkbox"/>	

Comments:

General Health History

Physician's Name:

Describe any major medical problems you have had:

List the medications you are currently taking, or any that you have taken in the past that you feel may have affected your hearing.

List any allergies including, medications, foods, or environmental irritants:

Check all that apply and describe details in comment section:

<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Mumps, Measles	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	HIV+
<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>		<input type="checkbox"/>	

Hearing Loss History:

When did you first notice difficulty hearing?

List situations where you notice hearing difficulty.

Do other family members notice or comment on your hearing loss?

List family members who have experienced hearing loss, the age they acquired their hearing loss, how they are related to you, and what you believed caused their hearing loss?

Do you have any of the following? Check all that apply and describe in comment section:

<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Tinnitus/ Ringing in ears	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Difference between ears? If so, which ear is better?
--------------------------	-----------	--------------------------	------------------------------	--------------------------	-----------	--------------------------	--

Comments:

Occupational Hearing History

Have you ever exposed your ears to loud sound without the use of Hearing Protection Devices? If yes, please describe all incidents.

Check all that apply and describe details in comment section:

<input type="checkbox"/>	Military service	<input type="checkbox"/>	Noise exposure at work	<input type="checkbox"/>	Recreational noise exposure	<input type="checkbox"/>	Hobbies that make loud noise
<input type="checkbox"/>	Guns	<input type="checkbox"/>	Farm equipment	<input type="checkbox"/>	Power tools	<input type="checkbox"/>	Engine noise

Hearing Aid History

Have you ever worn a hearing aid(s)? If so, where did you purchase them? What was the name of the manufacturer and the style (Behind-the-Ear, In-the-Ear, In-the-canal).

Describe your experiences with the hearing aid(s). What did you like and dislike about the sound, performance, and fit?

I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to Veronica H. Heide, Au.D. , Audible Difference LLC.

Signature:

Date: