

**Group Home – Adult Case History**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Length of Residence \_\_\_\_\_ Functional Level \_\_\_\_\_

Referred by \_\_\_\_\_ Physician \_\_\_\_\_

Guardian/POA \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Form completed by : \_\_\_\_\_

**Hearing Loss History and Present Status**

- A. Why are you here? \_\_\_\_\_
- B. Is hearing loss suspected? \_\_\_\_\_ Why? \_\_\_\_\_
- C. Which is better ear? Right \_\_\_\_\_ Left \_\_\_\_\_
- D. Is hearing status the same from day to day? \_\_\_\_\_
- E. Is sign language used? \_\_\_\_\_ If so will you need an interpreter during your visit? \_\_\_\_\_ (if the answer is yes, please call us at 812-855-7439) we will provide one for the client.

**Medical History (check all that apply)**

- Head injury with unconsciousness/when: \_\_\_\_\_
- Ear pain ( Right  Left  Both) Onset/Describe: \_\_\_\_\_
- Discharge from the ear ( Right  Left  Both) Onset/Describe: \_\_\_\_\_
- Fullness or pressure ( Right  Left  Both) Onset/Describe: \_\_\_\_\_
- Ear deformity ( Right  Left  Both) Onset/Describe: \_\_\_\_\_
- Visible congenital or traumatic deformity of the ear ( Right  Left  Both) Onset/Describe: \_\_\_\_\_
- Ear wax accumulation ( Right  Left  Both) Onset/Describe: \_\_\_\_\_
- Foreign Body in ear ( Right /  Left  Both) Onset/Describe: \_\_\_\_\_

**History of Ear Infections:**  Yes  No

Ear:  Right  Left  Both Age of Onset: \_\_\_\_\_ Age of last infection: \_\_\_\_\_

Treatment: \_\_\_\_\_

Remarks/Describe: \_\_\_\_\_

**Ear Surgery:**  Yes  No

Ear:  Right  Left  Both Type/Date of Surgery: \_\_\_\_\_

Remarks/Describe: \_\_\_\_\_

Noise Exposure (On the job, farm equipment, fireworks) \_\_\_\_\_

Any Known Syndromes? \_\_\_\_\_

**Vestibular/Balance History:**  Yes  No

Vertigo:  Yes  No

Other vestibular symptoms:  Light-Headedness  Spinning sensation  Unsteadiness  Imbalance Accompanying

Symptoms:  Nausea  Change in or onset of tinnitus  fluctuating hearing loss

Fullness or Pressure  Other: \_\_\_\_\_

Two or more falls in the past year or once with an injury:  Yes  No

Do you take Vitamin D?  Yes  No

Vestibular/Balance Treatment(s): \_\_\_\_\_

Remarks/Describe: \_\_\_\_\_

**Hospitalizations/Surgeries (Date/Type):** \_\_\_\_\_

**Medical Conditions:**

Diabetes  Cancer  Depression  Multiple Sclerosis  Heart Disease  Vascular Conditions

Meningitis  Autoimmune Disease  Head injury  Psychiatric  HIV/AIDS  Migraines

Neurologic conditions  Visual Issues  Other \_\_\_\_\_

Tobacco use in the last two years:  Yes  No

Type of tobacco product:  cigarettes/cigars/pipes  electronic-cigarette  chewing tobacco

Alcohol Use:  Yes  No Frequency: \_\_\_\_\_

Recreational drug or marijuana use:  Yes  No Frequency: \_\_\_\_\_

**Current Medications: (Include name, dosage and frequency)**

Name	Dosage	frequency

**Audiological History**

A. Any known family history of hearing loss occurring before 50 years of age? \_\_\_\_\_

B. Previous hearing tests and known results? \_\_\_\_\_

C. Hearing aid use in the past? \_\_\_\_\_ Currently wear them? \_\_\_\_\_  
Purchased where? \_\_\_\_\_

**Communicative Abilities**

A. Type of communication (verbal, gestures, sign language, etc) \_\_\_\_\_

B. How well are simple instructions and commands understood? \_\_\_\_\_

C. Mark the tasks that could be completed:

Repeating words \_\_\_\_\_ Pointing to pictures \_\_\_\_\_ Identifying body parts \_\_\_\_\_

Placing a peg in a board \_\_\_\_\_ Dropping a block in a bucket. \_\_\_\_\_

D. Would a negative reaction be anticipated towards:

Strangers \_\_\_\_\_ Wearing headphones \_\_\_\_\_ Examining ears \_\_\_\_\_

Conditioning to a simple tasking \_\_\_\_\_