



**SOUTHEASTERN  
LOUISIANA UNIVERSITY**

**Audiology Case History**

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

Home Address \_\_\_\_\_  
street city state zip

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

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

Reports to be sent to \_\_\_\_\_

Name (and relationship) of person filling out form \_\_\_\_\_

Address \_\_\_\_\_  
street city state zip

**EMPLOYMENT HISTORY/MILITARY HISTORY (from most recent):**

Place Date Position

1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



3. \_\_\_\_\_

What is their occupation?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Do they have any hobbies?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**EDUCATIONAL HISTORY**

<u>School</u>	<u>Location</u>	<u>Highest Grade/Degree Completed</u>	<u>Date</u>
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**DESCRIBE YOUR PRESENT HEALTH:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there a history of:

Yes No

Yes No  
Allergies

\_\_\_\_\_

Number

\_\_\_\_\_

Sinus

Infection \_\_\_\_\_

\_\_\_\_\_

Paralysis/pares  
is \_\_\_\_\_

\_\_\_\_\_

Anemia \_\_\_\_\_

Incoordination of \_\_\_\_\_

Asthma

\_\_\_\_\_

Tongue  
Muscles \_\_\_\_\_

Broken Nose

\_\_\_\_\_

Influenza

\_\_\_\_\_

Bronchitis

\_\_\_\_\_

Mouth-breathi  
ng \_\_\_\_\_

Chronic Colds

\_\_\_\_\_

Mumps

\_\_\_\_\_

Chronic  
laryngitis \_\_\_\_\_

\_\_\_\_\_

Pneumonia

\_\_\_\_\_

Chronic  
rhinitis \_\_\_\_\_

\_\_\_\_\_

Physical  
defect \_\_\_\_\_

Cleft Palate

\_\_\_\_\_

Poliomyelitis

\_\_\_\_\_

Diabetes

\_\_\_\_\_

Rheumatic  
fever \_\_\_\_\_  
Diphtheria \_\_\_\_\_

Scarlet  
fever \_\_\_\_\_

Ear disease \_\_\_\_\_

Retarded  
sexual \_\_\_\_\_  
Otitis Media \_\_\_\_\_

development

Otitis Externa \_\_\_\_\_

Syphilis

Hearing  
problem \_\_\_\_\_

Typhoid Fever

Hearing aid(s) \_\_\_\_\_

Tremor/Twitting  
Tinnitus \_\_\_\_\_

Ulcers \_\_\_\_\_

Emotional  
difficulty \_\_\_\_\_

Psychological

Glasses

counseling

Visual problem

Whooping cough

Smoking

Drinking

How much per day?

How much per day?

If the answer to any of the above items is yes, give the relevant details (e.g., how frequent are the episodes, how severe are these episodes, do you hear better in one ear vs. the other, etc.?)

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

List periods of hospitalization or medical treatment:

Hospital/City/State

Date

Reason

- 1.
2.
3.

List all surgical procedures: \_\_\_\_\_

List all prescription and nonprescription medication used over the past year (name the type if you cannot remember the generic name, i.e.; aspirin allergy pills).

\_\_\_\_\_
\_\_\_\_\_

Have you had a neurological examination? \_\_\_\_\_ If so, by who, when and where? \_\_\_\_\_

\_\_\_\_\_

If you speak a language other than English, please state the language \_\_\_\_\_

Are you bilingual? \_\_\_\_\_

Please describe in your own words the nature of your communication problems. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you think caused the problem? \_\_\_\_\_

When did you first notice its presence? \_\_\_\_\_

What were the circumstances? \_\_\_\_\_

How do you feel your hearing has affected your social life? \_\_\_\_\_

How do you feel your hearing problem has affected your occupation? \_\_\_\_\_

If you didn't have a hearing problem, how would your life be different? \_\_\_\_\_

Describe the reaction of people, including your immediate family, to your hearing problem? \_\_\_\_\_

Do any specific communication situations present difficulty for you? Explain. \_\_\_\_\_

Do you avoid any communication situations? Explain. \_\_\_\_\_

List interests you have or activities you engage in (clubs, hobbies, organizations, etc.) \_\_\_\_\_

What, if anything, have you tried to do to correct the hearing problem? \_\_\_\_\_

Are you coming to the Speech and Hearing Clinic on your own? \_\_\_\_\_

On the advice of another? \_\_\_\_\_

Have you ever received any prior speech or hearing evaluation? \_\_\_\_\_

Therapy? \_\_\_\_\_

Agency \_\_\_\_\_

Agency \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Dates \_\_\_\_\_

Dates \_\_\_\_\_

Results \_\_\_\_\_

Results \_\_\_\_\_

Did prior evaluation/therapy relate to the present problem?

\_\_\_\_\_

How effective has prior therapy been in helping you with your problem (what helped the most/least)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long has the present problem existed? \_\_\_\_\_

Has the nature of the problem changed at any time? \_\_\_\_\_

Explain. \_\_\_\_\_

List any additional sources of information which may be helpful to us in assisting with your problem: \_\_\_\_\_

\_\_\_\_\_

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